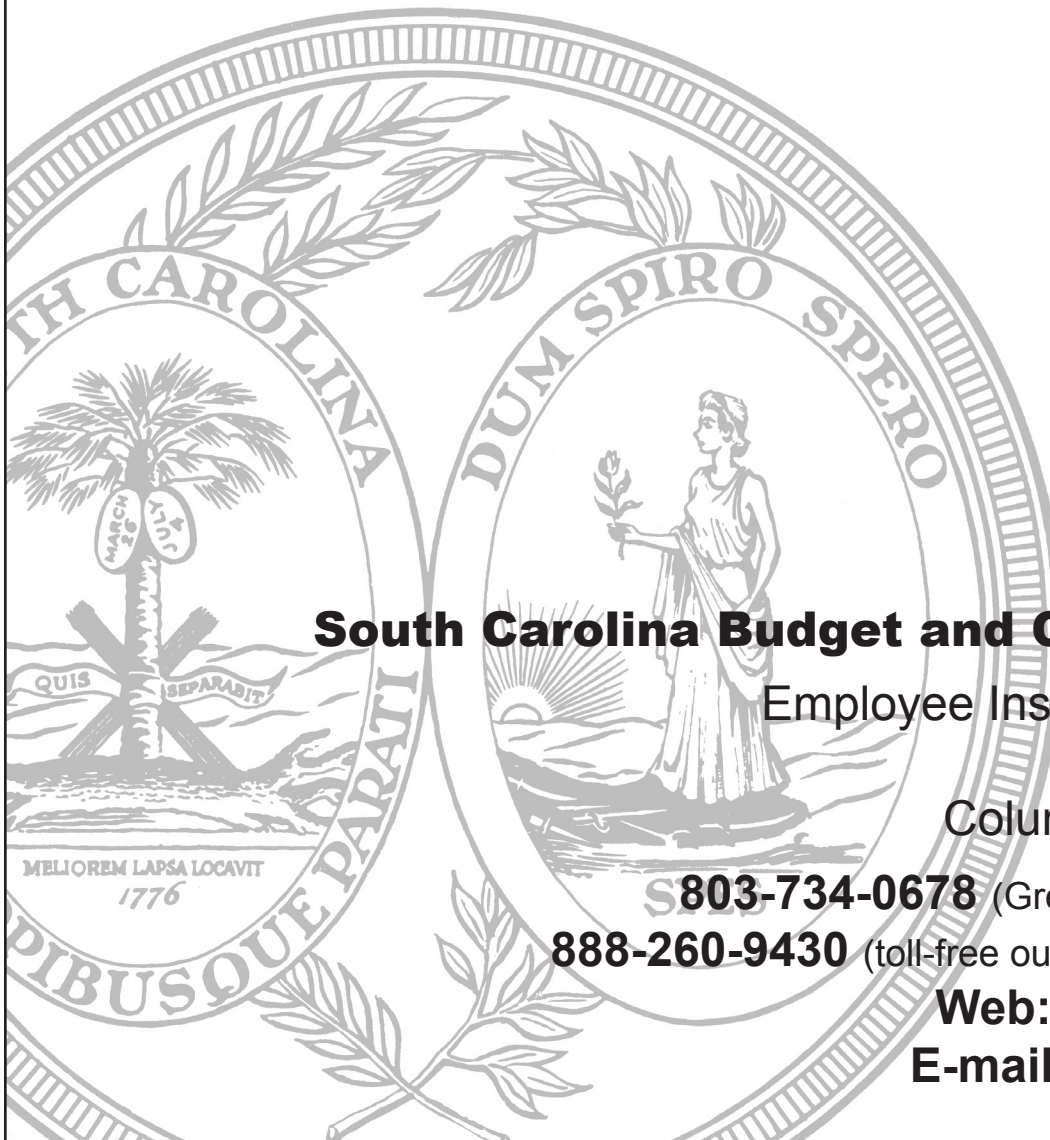


2008

Insurance Orientation Handbook



South Carolina Budget and Control Board

Employee Insurance Program

P.O. Box 11661

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Introduction

Your insurance benefits are important to you and to your family. Consequently, helping you understand those benefits is important to us. This handbook is for new employees of employers that participate in the state insurance program and employees of employers that have just joined the state insurance program. It will guide you through enrollment and will give you information that will help you make the insurance choices that best suit your needs.

Certain benefit options are based on your annual salary, so you may need to contact your personnel office to obtain this information. Bring this handbook and any information and documentation you may need, including your annual salary, to your orientation meeting.

The 2008 monthly premiums for the insurance plans are listed, beginning on page 38. If you are paid twice each month, half of your monthly premiums will be deducted from each check. If you are interested in health maintenance organization (HMO) coverage, you may contact the HMO for benefits information. Telephone numbers for each of the HMOs are on the inside cover of this guide.

Please note: This booklet is only a brief summary of the insurance benefits that are now available to you. For more detailed information about your coverage and how to use it, please refer to the materials offered by the HMOs, the *Tax-Favored Accounts Guide* from FBMC and your 2008 *Insurance Benefits Guide*. You may also contact your benefits office or visit the Employee Insurance Program Web site at www.eip.sc.gov.

Please take the time to review this book and discuss your benefits choices with family members before attending your orientation meeting. An overview of the insurance benefits programs will be presented during orientation. At the end of the meeting you will need to make your benefits choices.

BENEFITS ADMINISTRATORS AND OTHERS CHOSEN BY YOUR EMPLOYER WHO MAY ASSIST WITH INSURANCE ENROLLMENT AND ADJUSTMENTS, RETIREMENT OR TERMINATION AND RELATED ACTIVITIES ARE NOT AGENTS OF THE EMPLOYEE INSURANCE PROGRAM AND ARE NOT AUTHORIZED TO BIND THE EMPLOYEE INSURANCE PROGRAM.

THIS BOOKLET CONTAINS AN ABBREVIATED DESCRIPTION OF INSURANCE BENEFITS. THE PLAN OF BENEFITS DOCUMENTS AND BENEFITS CONTRACTS CONTAIN COMPLETE DESCRIPTIONS OF THE HEALTH AND DENTAL PLANS AND ALL OTHER INSURANCE BENEFITS. THEIR TERMS AND CONDITIONS GOVERN ALL HEALTH BENEFITS OFFERED BY THE STATE. IF YOU WOULD LIKE TO REVIEW THESE DOCUMENTS, CONTACT YOUR BENEFITS ADMINISTRATOR OR THE EMPLOYEE INSURANCE PROGRAM.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

General Information

Take advantage of these programs and publications offered through the Employee Insurance Program.

WORKSITE SCREENINGS

Active employees, retirees and their covered spouses who are not Medicare eligible and whose primary coverage is one of the health plans offered through the Employee Insurance Program can pay \$15 for a routine health screening. This includes a health risk appraisal, blood lipid profile, blood chemistry profile, hemogram, blood pressure measurement, height and weight measurement and counseling on individual health risk factors. The screening, conducted at your worksite, is administered through Prevention Partners. You may participate in only one screening per year.

Prevention Partners also conducts chronic disease management workshops on asthma, diabetes, hypertension, healthy heart and weight loss. These workshops are held statewide and are free to employees and their family members. Contact your Prevention Partners coordinator or benefits office for more information.

VISION CARE PROGRAM

If you are a full-time or part-time employee, retiree, survivor or COBRA participant, you may take advantage of this program. Your dependents also are eligible. You do not have to subscribe to the State Health Plan or an HMO. Tell your provider you are a participant in the Vision Care Program. If you do not, you may not receive the discount. You may be required to show your provider some type of state-related identification to prove your eligibility.

Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than \$60 for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may have to pay additional charges because that usually requires additional services.

Participating providers, including opticians, have agreed to give a 20 percent discount on all eyewear. The discount does not apply to disposable contact lenses. Participating providers are listed in the Vision Care Program Directory available on the EIP Web site at www.eip.sc.gov. The Vision Care Program is not associated with any state group health coverage. There are no claims to file and no reimbursement of fees.

If you are covered under another vision care program, you can have the benefits offered under this program or through your other coverage, but not both.

SMOKING CESSATION

The research-based Free & Clear® Quit For Life™ Program is available at no charge to State Health Plan, BlueChoice HealthPlan and MUSC Options subscribers and their covered dependents age 18 and older.

One of the most successful programs of its kind, the Quit For Life Program helps participants stop using cigarettes, cigars, pipes and smokeless tobacco. A professionally trained Quit Coach™ works with each participant to create a personalized quit plan. As part of the 12-month program, participants receive Quit Guides and five telephone calls from a Quit Coach. A participant may call Free & Clear's toll-free support line as often as he wishes. See page 58 of your 2008 *Insurance Benefits Guide* for more information.

CIGNA HMO subscribers can participate in the CIGNA Quit TodaySM Tobacco Cessation Program. The year-long program includes unlimited calls to a coach, an optional relapse support group via telephone and over-the-counter nicotine gum or patches, if appropriate. Call 800-244-6224 for more information.

EIP ON THE INTERNET

Like many organizations, the Employee Insurance Program (EIP) offers helpful information through the Internet at www.eip.sc.gov. You will find ideas about how to make the best use of your insurance, as well as links to the Web sites of EIP's third-party administrators.

EIP DIRECT

EIP Direct is a bimonthly newsletter sent to your benefits administrator, who may send you the information or the newsletter itself. The newsletter gives you information about changes in benefits, answers questions about benefits and tells you about programs that may be of interest to you, such as Prevention Partners chronic disease workshops. *EIP Direct* can be viewed on the EIP Web site, www.eip.sc.gov. Choose "News & Updates" and then "Newsletters."

INSURANCE BENEFITS GUIDE

You can also view the 2008 *Insurance Benefits Guide* (IBG) on the EIP Web site. Select "Choose Your Category," which is on the left side of the home page, and you will see a list of the types of subscribers served by EIP. After you click on your category (Active Subscribers), select "Publications" and "Insurance Benefits Guide."

The IBG includes explanations of benefits, premiums and contact information and an overview of the health plans and other programs offered through EIP.

MYBENEFITS — EIP'S ONLINE ENROLLMENT SYSTEM

Access to your benefits information is just a click away with MyBenefits, the Employee Insurance Program's (EIP) online enrollment system. Through MyBenefits, you can update your beneficiaries and contact information and print a copy of your benefits statement anytime you have access to the Internet — 24 hours a day, seven days a week. During the enrollment period each October, you can make your own coverage changes. See page 22 of your 2008 *Insurance Benefits Guide* for more information.

Eligibility Rules

These are the rules used to determine whether employees and their dependents are eligible for insurance coverage. There are specific eligibility rules for retirees (see pages 7-9).

EMPLOYEES

An eligible active employee:

- Is employed by the state, a school district or a participating local subdivision
- Works in a permanent, full-time position as defined by his employer and
- Receives compensation from a department, agency, board, commission or institution of the state, a school district or a participating local subdivision.

If you are an eligible employee of a participating employer in South Carolina, you can enroll in a health plan or an HMO, and the dental plan, within 31 days of the date you are hired.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of participating county or municipal councils, who also participate in the S.C. Retirement Systems (SCRS), are considered employees for insurance purposes. If you work for more than one participating employer, please contact your benefits administrator for further information. Permanent, part-time teachers are eligible for state health, dental, Dental Plus, MoneyPlu\$ and vision care benefits.

DEPENDENTS

SPOUSE

You may cover either your lawful spouse or former spouse (if you are required to do so by a divorce decree or court order), but not both your spouse and former spouse. If you are required to provide health insurance only for your former spouse, you may cover your current spouse under other policies, including dental, Long Term Care and Dependent Life.

- If you are under a court order to insure your ex-spouse after a divorce, bring a complete copy of the divorce decree or Family Court decree to your orientation meeting. The document must stipulate the programs under which the ex-spouse must be covered.
- If you are in a common-law marriage, bring a notarized statement signed by both parties.
- If your spouse is a covered employee or retiree of a participating employer and is carrying you on his insurance, you must be removed from his coverage and enrolled with your own employer.
- You must provide your spouse's date of birth and Social Security Number.

Dependents who lose coverage due to a qualifying event may be eligible to continue coverage under COBRA. For more information, you must contact your benefits administrator or EIP as soon as possible, but no later than within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

CHILDREN

You may cover any of your unmarried children who are under age 19 and are principally dependent (more than 50 percent) upon you for maintenance and support. This includes a natural or adopted child, stepchild, foster child (a child placed with you by an authorized placement agency and for whom you care as you would your own child) or a child for whom you have legal custody and who resides in the home in a normal parent/child relationship, or for whom you (the employee) provide support and maintenance because of a court order.

- If you are required to insure a dependent child after a divorce, please bring a complete copy of the divorce decree or Family Court decree to your orientation meeting. The document must stipulate the programs under which the child must be covered.
- If you have gained custody or guardianship of a child, please bring a copy of the court order or other legal documentation from a placement agency or DSS, granting custody or guardianship of a child/ foster child to the subscriber. The documentation must verify the subscriber has guardianship responsibility for the child and not merely financial responsibility.
- If you have adopted a child, please bring a copy of legal adoption documentation from the court, verifying the completed adoption; or a letter of placement from an attorney, adoption agency or DSS, verifying the adoption in progress.
- If both you and your spouse are employees or retirees of a participating employer, only one of you may cover your eligible dependents.
- You must provide dates of birth and Social Security Numbers for your dependent children.

You may insure an unmarried child, age 19-24, who is a **full-time student** as defined by the institution and who is principally dependent (more than 50 percent) upon you for maintenance and support.

- You must bring the statement on letterhead from the educational institution stating the student is full time as of the date of his 19th birthday and including the dates of enrollment.
- You must also provide dates of birth and Social Security Numbers for your dependent children.

You may cover an unmarried child who is **incapable of self-sustaining employment** because of mental illness or physical handicap and who is primarily dependent (more than 50 percent) upon you for maintenance and support. The child must have been incapacitated while an eligible dependent. Coverage for your incapacitated dependent child is contingent upon approval from EIP.

- Please bring a completed Incapacitated Child Certification Form (available from your benefits office or the EIP Web site at www.eip.sc.gov) to your orientation meeting. If the child is age 19-24, you must also include a letter from the school he was attending stating that he was a full-time student up to the date of incapacitation and that he is no longer a full-time student.
- Also complete and attach an Authorized Representative Form signed by the incapacitated child. If applicable, you may forward a copy of guardianship papers from the probate court for your incapacitated child. Either of these documents gives EIP permission to discuss or disclose the child's protected health information with the child's Authorized Representative.

RETIREES

Retirees **from employers that participate in the state insurance program** are eligible for insurance coverage if they retire:

- Due to years of service with a participating state insurance employer
- Due to age
- On approved disability through the South Carolina Retirement Systems (SCRS)
- On approved Basic Long Term Disability and/or Supplemental Long Term Disability.

To qualify for the retiree group insurance program as either a non-funded or a funded retiree, your last five years of employment must be served continuously and consecutively, with an employer that participates in the Employee Insurance Program, and in a full-time, permanent position.

Additional service credit for unused sick leave may not be used to qualify for the retiree group insurance program.

If you and/or your dependents are not covered at the time of your retirement, you may enroll within 31 days of your retirement date or within 31 days of a special eligibility situation (see page 31). You will then be subject to pre-existing condition exclusions for 12 months. A Certificate of Creditable Coverage may be used to reduce the limitation period. See page 11 for more information.

State Optional Retirement Program retirees must meet the same insurance eligibility guidelines as S.C. Retirement Systems participants.

Please note: Whether you are a funded or a non-funded retiree, these types of service do not count toward your 5-, 10- or 20-year requirement for insurance eligibility: non-qualified, federal, military, out-of-state employment, unused sick leave or service with employers that do not participate in the state insurance program.

If you are not eligible for insurance as a retiree, you may still be eligible to continue coverage under COBRA (see page 12).

FUNDED VS. NON-FUNDED RETIREE INSURANCE PREMIUMS

If you are a state or school district retiree and qualify for funded benefits, the state will contribute as much to your premiums as it contributes to the premiums of an active employee. Local subdivisions may or may not pay a portion of the cost of their retirees' group insurance premium and may include an administrative fee and an experience rating. Each subdivision develops its own policy for funding retiree insurance premiums.

A local subdivision is a public employer in South Carolina that falls within one of the categories established by Section 1-11-720 of the 1976 S.C. Code of Laws, as amended, such as a city or county, and participates in the state insurance program. **If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.**

FUNDED RETIREES

Funded retirees are those whose employer contributes to their retiree insurance premiums *and whose last five years of employment were continuous and consecutive in a permanent, full-time position with an employer that participates in the state insurance program*. They must meet one of these guidelines:

- Employees who are eligible to retire and have 10 or more years of earned S.C. Retirement Systems (SCRS) service credit with an employer that participates in the state insurance program.
- Employees who leave employment before they are eligible to retire but who have 20 or more years of earned SCRS service credit with an employer that participates in the state insurance program. However, they are not eligible for insurance coverage until they are eligible to receive a retirement check at age 60. Employees who qualify under the Police Officers Retirement System (PORS) become eligible at age 55.
- **An exception:** Employees who left employment before 1990 and who were not of retirement age, but who had 18 years of earned SCRS service credit with an employer that participates in the state insurance program, returned to work with a participating group, enrolled in a state health and dental plan, and worked for at least two consecutive years in a full-time, permanent position.

NON-FUNDED RETIREES

Non-funded retirees are those who do not qualify for funded benefits (see above rules) and who must pay the full premium, which includes the retiree share *plus the employer contribution*. For retirees of local subdivisions, it may also include an administrative fee and an experience rating. To qualify, a retiree's last five years of employment must have been continuous and consecutive in a permanent, full-time position with an employer that participates in the state insurance program. Non-funded retirees include:

- Employees who retire at age 55 with at least 25 years of retirement service credit (including at least 10 years of earned service credit with an employer that participates in the state insurance program). You must pay the full insurance premium until you reach age 60 or the date you would have had 28 years of service credit, whichever occurs first. Although sick leave may increase service credit under SCRS, retirees must pay the entire premium until age 60 or until they reach the date they would have had 28 years of service credit if they had continued working. At the end of this period, you will

be eligible for funded retiree rates. This rule does not apply to Police Officers Retirement System, General Assembly Retirement System and Judges-Solicitors Retirement System participants. If you are in one of these groups, contact your benefits office for additional information. If you are retiring from a local subdivision, contact your benefits administrator for premium information.

- Employees who are eligible to retire and have at least five, but fewer than 10, years of earned SCRS service credit with a participating state insurance program employer.
- General Assembly members who leave employment before they are eligible to retire and have eight years of General Assembly Retirement System service credit.
- Former municipal and county council members who served on council for at least 12 years and were covered under the state's plan when they left the council. It is up to the county or municipal council to decide whether or not to allow former members to have this coverage.

TERI

If you are a Teacher and Employee Retention Incentive (TERI) program participant in a permanent, full-time position, your insurance benefits as an active employee continue. When your TERI employment ends, you must apply to continue your insurance benefits as a retiree (if eligible) within 31 days of your date of termination. Your service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward retiree insurance eligibility.

SURVIVORS

If you are a covered spouse or child of a deceased employee or funded retiree of a state agency or a school district, your health insurance premium will be waived for one year after the death of the covered employee or funded retiree. If you and your spouse are both covered employees or retirees at the time of death, your surviving spouse is not eligible for the premium waiver. Local subdivisions may elect to, but are not required to, waive the health premiums of survivors of retirees. After the first year, you must pay the full premium to continue coverage. Dental premiums are not waived. However, survivors can continue dental coverage by paying the full premium.

- If the deceased was a covered employee who was killed in the line of duty, health insurance premiums will be waived for one year for the covered surviving spouse and dependent children. After the one-year waiver, eligible survivors may continue coverage at the *employer-funded rate*. If the employer is a local subdivision, survivors should contact the employer for premium information.
- A surviving spouse who remarries becomes ineligible to continue coverage.
- A dependent child can continue coverage until he is no longer eligible as a dependent. If he is no longer eligible for coverage as a survivor, he may be eligible to continue coverage under COBRA. Contact EIP for details.

ELIGIBILITY APPEALS

If you are dissatisfied after an eligibility determination has been made, you may ask EIP to review the matter by making a written request to EIP within 90 days of notice of the decision. If the decision is upheld by EIP, you have 30 days to seek judicial review in the S.C. Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.

Enrollment

Your benefits administrator will let you know if he will be enrolling you through an online enrollment system. Otherwise, you must complete a Notice of Election (NOE) form. A sample Active NOE is on pages 33-34. To cover your eligible dependents, each dependent must be listed on the NOE form (section #6 of sample). The completed NOE must be submitted to your personnel office within 31 days of your date of hire. It may be helpful for you to practice completing the form before your orientation meeting. This will assist you in gathering the information you need for your orientation meeting.

You must complete separate applications to enroll in MoneyPlu\$ spending accounts or Long Term Care.

After you enroll, you should check your payroll stub to make sure your payroll deductions agree with the benefits and levels you selected. Your coverage selections will continue from one year to the next, with the exception of some MoneyPlu\$ accounts (see page 26), as long as you are an eligible employee — unless you elect changes during an enrollment period or after a special eligibility situation.

Do not forget to include your dependent's Social Security Number! If you have a dependent, age 19-24, who is a full-time student, you must bring verification of his student status (a statement on letterhead from the educational institution confirming student is full time and dates of enrollment).

WHEN COVERAGE BEGINS

Your coverage begins on the first day of the month if you are actively at work on the first working day of the month. Otherwise, it starts on the first day of the following month. Your enrolled dependents' coverage begins same day yours does.

COORDINATION OF BENEFITS

Some families in which one spouse works for a participating employer and the other works for an employer that is not covered through EIP are eligible to enroll in two health plans. While the additional coverage may mean that more of your medical expenses are paid by insurance, you will probably pay premiums for both plans. Weigh the advantages and disadvantages before you purchase extra coverage.

Most health plans have a system to determine how claims are handled when a person is covered under more than one insurance plan. This is called "coordination of benefits" (COB). When a subscriber has coverage under more than one plan, he can file a claim for reimbursement from each plan. Plan administrators, such as BlueCross BlueShield of South Carolina or your HMO, coordinate benefits so that you get the maximum reimbursement allowed. That amount will never be more than 100 percent of your covered medical, dental or prescription drug expenses.

There are rules that determine the order in which the plans pay benefits. The plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is primary.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan or HMO coverage is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

COORDINATION OF BENEFITS WITH MEDICARE

If you are eligible for Medicare and are enrolled as an active employee through the Employee Insurance Program (the State Health Plan, BlueChoice HealthPlan, CIGNA HMO, or MUSC Options), your health coverage through EIP is primary. (Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.) When you enroll as a retiree, Medicare Parts A and B become your primary coverage. **It is important to enroll in Medicare Part B when you become eligible for Medicare. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare cost that Part B would have paid.** In the case of Medicare Part D, the drug coverage you have through the State Health Plan or through your health maintenance organization is as good as, or better than, coverage offered through Part D. Therefore, most people should not sign up for Part D.

There is an exception: If you are covered by Medicare, you may be eligible for higher benefits under Part D if your resources are limited. Under these conditions, Part D could lower your out-of-pocket drug costs. If you feel you may qualify for this additional assistance, contact Social Security at 800-772-1213 or at 800-325-0778 (TTY), for the hearing impaired.

IMPORTANT MEDICARE NOTE:

If you or one of your dependents become eligible for Medicare, you must notify EIP within 31 days of Medicare eligibility. **If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:**

- **Immediately begin paying benefits as if you were enrolled in Medicare.**
- **Seek reimbursement for over-paid claims back to the date you or your dependent(s) became eligible for Medicare.**

LATE ENTRANT

A late entrant is a full-time employee, retiree or dependent who did not enroll within 31 days of his first date of eligibility, but who later enrolls during open enrollment. A late entrant is subject to a pre-existing condition exclusion for 18 months after coverage begins. See below and page 30 for more information.

WHAT TO DO IF YOU PREVIOUSLY HAD HEALTH INSURANCE

When you enroll in the plan, proof of a *Certificate of Creditable Coverage* from your previous insurance company may be used to reduce or eliminate a *pre-existing condition* exclusion, if there was no *significant break in coverage* (any break in coverage more than 62 days is a significant break in coverage).

Creditable coverage is previous coverage under a group health plan or insurance coverage or health benefits provided by state and federal law. To document creditable coverage, you must present to your benefits administrator a creditable coverage letter or a letter on letterhead from your previous employer that includes the dates coverage began and ended (or that it is still in effect), the names of all individuals covered and the types of coverage.

A *pre-existing condition* is any medical condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended by, or received from, a licensed healthcare provider in the six months before the covered person enrolled in the plan. Benefits for a pre-existing condition are payable only for treatment given 12 months after the date a covered person enrolled, or 18 months after the date a late entrant enrolled. But if you had creditable coverage under another health plan or under other health insurance before your enrollment date, and there was not a significant break in health coverage (a break of more than 62 days), then your pre-existing condition exclusion period would be reduced by the total amount of your prior coverage.

For purposes of applying the pre-existing condition limitation, a *significant break in coverage* is a period of more than 62 consecutive days during which the individual does not have any creditable coverage. Neither a waiting period, nor an affiliation period (the time an HMO may require you to wait after you enroll and before your coverage begins), is taken into account in determining a significant break in coverage.

COBRA

COBRA is short for the *Consolidated Omnibus Budget Reconciliation Act*. It requires that continuation of group insurance coverage be offered to you and to your covered dependents if you are no longer eligible for coverage under this Plan.

You can continue your coverage for a limited time under COBRA if you and/or your covered dependents lose coverage because:

- Your working hours are reduced from full-time to part-time
- You voluntarily quit work, are laid off or are fired (unless the firing is due to gross misconduct)
- You are a separated or divorced spouse or
- You are no longer eligible as a dependent child.

If the event is not reported by you or your dependent within the 60-day limit, COBRA coverage will not be offered. Rules and regulations governing continuation of coverage under COBRA are described in your *Insurance Benefits Guide*. If you need additional information, you may contact EIP. If you are enrolled through a local subdivision, contact your benefits office.

INSURANCE CARDS

If you enroll in the State Health Plan Standard Plan, Savings Plan or Medicare Supplemental Plan, BlueCross BlueShield of South Carolina will send you insurance cards for you and your eligible dependents. BlueChoice HealthPlan, CIGNA Healthcare and MUSC Options will mail insurance cards to their members. Dental and Dental Plus subscribers will receive insurance cards from BlueCross BlueShield of South Carolina.

All insurance cards for all family members are issued in the subscriber's name only.

BENEFITS IDENTIFICATION NUMBER

For your protection, the Employee Insurance Program assigns each subscriber an eight-digit Benefits Identification Number (BIN). This unique number is used instead of a Social Security Number (SSN) in e-mails and written communication between EIP and you and your dependents.

When you contact EIP, you may give your SSN or your BIN, and the Customer Service staff will be able to assist you.

BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and MUSC Options put your BIN on your identification card. The BIN is also used on Dental Plus cards. CIGNA gives its members another secure number. If you are not enrolled in a program that uses the BIN, EIP will send you a letter giving you your number.

Keep a record of your BIN in a safe place. Active employees need it to use MyBenefits, EIP's online enrollment system. However, you can also get your BIN through MyBenefits. See page 22 of your 2008 *Insurance Benefits Guide* for more information.

Choosing a Health Plan

ENROLLMENT PERIODS

There are two types of enrollment periods: **annual enrollment** and **open enrollment**. Annual enrollment, held every year in October, is a period during which eligible employees and retirees may change health plans. Retirees may change to and from the Medicare Supplemental Plan. No other changes are allowed. Open enrollment, held in October of odd-numbered years, is a period during which eligible employees, retirees, survivors and COBRA subscribers may enroll in or drop their own coverage and add or drop eligible dependents to/from a health plan and/or dental plan without regard to any special eligibility situations. See page 31 for more information on special eligibility situations.

Enrollment changes made during these periods become effective January 1.

WHAT ARE MY CHOICES?

THE STATE HEALTH PLAN (SHP)

The SHP is a Preferred Provider Organization (PPO) that has arrangements with doctors, hospitals and other providers who have agreed to accept the Plan's allowable charges for covered medical services as payment in full and will not *balance bill* you. (Balance billing is when a provider charges more for medical services than the Plan allows.) Participating providers also file the claims for you. An SHP subscriber is free to use any physician or hospital he or she chooses, with the exceptions of behavioral health providers and pharmacies. However, a subscriber will receive the highest level of benefits if her/his care is provided by an SHP network participant. The SHP has three options: the *Standard Plan*, the *Savings Plan* and the *Medicare Supplemental Plan*. The Standard and Savings plans are offered statewide to active employees, COBRA subscribers, survivors and retirees. (Retired subscribers who are eligible for Medicare may not enroll in the Savings Plan.) The Medicare Supplemental Plan is offered statewide to retirees and survivors who are eligible for Medicare.

TRADITIONAL HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

An HMO is a managed care plan that requires subscribers to see only providers within its network. If you receive care outside the network, the HMO will not pay benefits for these services unless the care is preauthorized or you have a life- or limb-threatening illness or injury. You are required to choose a primary care physician (PCP) who coordinates all aspects of your healthcare. To receive benefits, you must receive a referral from your PCP before you see a specialist. Active employees must live or work in an HMO service area to enroll in its plan. Retirees, COBRA subscribers and survivors must live in an HMO service area to enroll in its plan. Choices are:

- **BlueChoice HealthPlan** — offered **statewide**
- **CIGNA HMO** — offered in all counties **except Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.**

HMO WITH POINT OF SERVICE (POS) OPTION

A POS plan is an HMO that allows you to go to providers inside or outside its network. To receive the highest level of benefits, care must be obtained within the HMO network. When you use out-of-network services, you are likely to have much higher out-of-pocket expenses in the form of deductibles and co-payments. The only HMO with a POS option offered is **MUSC Options**, which is available in **Berkeley, Charleston, Colleton and Dorchester** counties. Active employees must live or work in this service area to enroll in the plan. Retirees, COBRA subscribers and survivors must live in the service area to enroll in the plan.

MAKING A DECISION

Choosing a health plan requires thought and planning. Costs, services provided, benefits offered and provider networks are all major factors to consider when making a health plan decision. Although no plan will cover all of your medical costs, there are plans that are better suited than others for you and your family's health needs.

You cannot predict exactly what your healthcare needs will be for the coming year, but you can anticipate to some extent what services you and your family might need. By taking the time to decide what benefits and services are important to you and your family and by comparing the available plans, you will be able to choose a health plan that is right for you.

WHAT BENEFITS ARE OFFERED?

Although most plans provide basic health coverage, the details are what count. When choosing a plan, you may want to find out how it covers:

- Specialist care
- Emergency room visits and hospitalizations
- Prescription drugs
- Mental health and substance abuse services
- Obstetrical-gynecological care and well child care visits
- Physical exams
- Health screenings and other preventive care
- Nursing home, home health and hospice care
- Physical therapy and other rehabilitative care
- Vision care
- Chiropractic or alternative health care
- Medical services outside the service area.

WHAT IS IMPORTANT TO ME?

Before choosing a health plan, decide what is most important to you. You may want to consider:

- How you feel about a primary care doctor making referrals for you
- How much responsibility, financially and otherwise, you are willing to take for your own healthcare
- Whether freedom to choose which doctor or hospital to use is important to you
- How comprehensive you want your healthcare coverage to be
- How important the cost is to you and how much you can pay in premiums, deductibles and other expenses
- Whether the plan offers benefits that meet your needs. Are you thinking about starting a family? Do you, or does a member of your family, have a chronic condition or disability?
- How does the plan provide coverage for family members who travel or attend college out of the state or out of the service area?

HOW DO I COMPARE PLANS?

When comparing the health plans, look at the services each plan offers. What services are limited or not covered (exclusions)? Which doctors, hospitals and other providers participate in the plan's networks (i.e., does your doctor participate)? Are the doctors accepting new patients? Do you need approval from the plan or your primary care physician before going to the hospital or receiving specialty care? Finally, compare the costs. Consider things such as deductibles, copayments, how much the plan will pay once your deductible has been met, how much the plan will pay if you use a non-participating provider and the limits on how much the plan will pay in a year or over a lifetime.

The State Health Plan

The State Health Plan offers employees who are not eligible for Medicare two choices: the **Standard Plan** and the **Savings Plan**. Each plan has its own cost-sharing provisions and share many features.

If you are willing to take greater financial responsibility for your healthcare costs and accept a higher annual deductible, you can save money on premiums by enrolling in the **Savings Plan**. Because it is a tax-qualified, high-deductible health plan, an eligible subscriber who enrolls in the Savings Plan and who has *no other health coverage, including Medicare, that is not a high-deductible health plan*, may establish a Health Savings Account (HSA). An HSA may be used to pay qualified medical expenses now and in the future.

With the **Standard Plan**, the annual deductibles are lower, but the premiums are higher. After you reach your deductible, you pay your coinsurance for allowable charges until you reach your coinsurance maximum. An allowable charge is the maximum amount a health plan (such as the State Health Plan, an HMO or Medicare) will pay for a covered service or for a product, such as a drug. Network providers have agreed to accept the allowable charge. After you reach your coinsurance maximum, the Standard Plan pays 100 percent of the allowable charges. However, per-occurrence deductibles still apply.

With the **Savings Plan**, the annual deductibles are much higher, but the premiums are much lower. After you reach your deductible, you pay your coinsurance for allowable charges until you reach your coinsurance maximum. The Savings Plan then pays 100 percent of allowable charges. There are no per-occurrence deductibles with the Savings Plan. However, no family member will receive benefits, other than preventive, until the \$6,000 family deductible (or the \$3,000 deductible if you have single coverage) has been met.

THE STATE HEALTH PLAN HOSPITAL NETWORK

All general hospitals in South Carolina participate in the SHP hospital network. Network hospitals accept the State Health Plan's allowable charges for covered services and will not balance bill you for the difference. Network hospitals also file your claims. You pay only the deductible, the coinsurance that applies to you and any non-covered charges.

Services at non-network hospitals are covered, but non-network hospitals can balance bill you for the difference between the State Health Plan's allowable charge and their charge. You will also be responsible for paying an additional 20 percent in coinsurance, which is the out-of-network differential (see page 16).

Ambulatory Surgical Center Network

The Ambulatory Surgical Center Network includes ambulatory surgical centers around the state that provide some of the same services obtained from the outpatient department of a hospital. These surgical centers accept State Health Plan allowable charges and will not balance bill you for the difference. You just pay the applicable deductible and coinsurance. Medically necessary services at non-network ambulatory surgical centers are covered, but you may pay more.

THE STATE HEALTH PLAN PHYSICIAN NETWORK

If you need to see a medical doctor, you may benefit from using the SHP Physician Network. The SHP Physician Network is an open network, which means all eligible doctors in the state were invited to participate. Since network physicians have agreed to accept the Plan's allowable charges for covered medical services, you will pay only your deductibles, your coinsurance and any non-covered charges.

THE BLUECARD PROGRAM

You have access to doctors and hospitals almost everywhere with the BlueCard Program administered by BlueCross BlueShield of South Carolina. This program applies to your medical benefits. Please refer to the Behavioral Health Benefits section on page 20 to see how mental health and substance abuse benefits are handled. With the BlueCard Program, you still have the freedom to choose the doctors and hospitals that best suit you and your family. Follow these steps for health coverage when you are away from home but within the United States:

1. Always carry your SHP ID card.
2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard Access at 800-810-2583.
4. Call Medi-Call or APS for preauthorization, if necessary.
5. When you arrive at the participating doctor's office or hospital, simply show your SHP ID card. As a BlueCard program member, the doctor should recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.

After you receive care, you should not have to complete any claim forms. You should not have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayment, coinsurance and non-covered services). You will be mailed a complete explanation of benefits.

OUTSIDE THE U.S.

Through the BlueCard Worldwide® program, your State Health Plan ID card gives you access to doctors and hospitals in more than 200 countries and territories around the world and to a broad range of medical assistance services. For more information, see page 36 of your 2008 *Insurance Benefits Guide*.

Note: BlueCard Worldwide® coverage is **not** available to Medicare Supplemental Plan subscribers.

OUT-OF-NETWORK BENEFITS

With the State Health Plan, you may choose which provider to use. However, if you choose a provider that does not participate in a SHP network or the BlueCard program, you will pay 20 percent more in coinsurance. This means that after you meet your deductible, you will be responsible for 40 percent of your covered expenses. Non-network providers are free to charge you any price for their services, so you may pay more than the State Health Plan's allowable charge.

Once you have met your deductible, here's how the **out-of-network differential** works if you are covered under the Standard Plan:

- If you have met your deductible and choose to see a non-network provider, you will be responsible for 40 percent, instead of the usual 20 percent, of the covered charges, any applicable per-occurrence deductibles, and you risk being balance billed. The plan will not begin paying 100 percent of your allowable charges until you have reached the out-of-network coinsurance maximum of \$4,000 for single coverage and \$8,000 for family coverage.

Once you have met your deductible, here's how the **out-of-network differential** works if you are covered under the Savings Plan:

- If you have met your deductible and choose to use a non-network provider, you will be responsible for 40 percent, rather than the usual 20 percent, of the covered charges. The plan will not begin paying 100 percent of your allowable charges until you have reached the out-of-network coinsurance maximum of \$4,000 for single coverage and \$8,000 for family coverage.

See the health plan comparison chart on pages 36-37 for more information.

Prescription drug and mental health and substance abuse benefits are only payable *if* you use a network provider.

MEDI-CALL

Certain services covered by the Standard Plan and the Savings Plan require approval before you receive them. A phone call gets things started. While your healthcare provider may make the call for you, it is your responsibility to see that the call for authorization is made.

You can reach Medi-Call by phone from 8:30 a.m. to 5 p.m., Monday through Friday, except holidays. You may fax information to Medi-Call 24 hours a day. However, Medi-Call will not respond until the next business day. If you do fax information to Medi-Call, provide, at a minimum, this information so the review can begin:

- Subscriber's name
- Patient's name
- Subscriber's Benefits ID Number or Social Security Number
- Information about the service requested
- A telephone number where you can be reached during business hours.

Medi-Call numbers are:

- 800-925-9724 (South Carolina, nationwide, Canada)
- 803-699-3337 (Greater Columbia area)
- 803-264-0183 (fax).

Medi-Call helps you and your covered family members receive appropriate medical care in the most beneficial, cost-effective manner. **Participation in Medi-Call is mandatory whether you are enrolled in the Standard Plan or in the Savings Plan.** You must contact Medi-Call at least 48 hours or two working days, whichever is greater, before receiving these medical services at any medical facility in the United States or Canada:

- You need inpatient care in a hospital¹
- Your preauthorized outpatient services result in a hospital admission (You must call again for the hospital admission.)
- You need outpatient surgery for septoplasty
- You need outpatient or inpatient surgery for a hysterectomy
- You need a sclerotherapy performed in an inpatient, outpatient or office setting
- You need a MRA, MRI, PET Scan or CT Scan
- You will be receiving a new course of chemotherapy or radiation therapy (one-time notification per course)
- You are admitted to a hospital in an emergency (Your admission must be reported within 48 hours or the next working day after a weekend or holiday admission.)¹
- You are pregnant (You must call within the first three months of your pregnancy.)
- You have an emergency admission during pregnancy²
- Your baby is born²
- Your baby has complications at birth
- You are to be, or have been, admitted to a long-term acute care facility, skilled nursing facility, need home healthcare, hospice care or an alternative treatment program
- You need durable medical equipment
- You or your covered spouse decides to undergo any in vitro fertilization procedure or any other infertility procedure
- You or your covered family member needs to be evaluated for a transplant
- You need inpatient rehabilitative services and related outpatient physical, speech and occupational therapy.

Savings Plan participants receive a free annual physical, described on page 19.

A preauthorization request for any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Call seven days before surgery (i.e., blepharoplasty, reduction mammo-plasty, TMJ or other jaw surgery, etc.)

¹*For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for preauthorization before a non-emergency admission or within 24 hours of an emergency admission.*

²*Contacting Medi-Call for the delivery of your baby does not add the baby to your health insurance. You must add your child by filing an NOE within 31 days of birth for benefits to be payable.*

Medi-Call approval does not guarantee payment of benefits. Claim payments are still subject to the rules of the plan.

If you do not call Medi-Call in the required situations, you will pay a \$200 penalty for each hospital or skilled nursing facility **admission**. In addition, the coinsurance maximum will not apply. In other words, you will continue to pay your coinsurance, no matter how much you pay out-of-pocket. **If you do not obtain preauthorization from APS, no mental health or substance abuse benefits will be paid.**

PREVENTIVE BENEFITS

MAMMOGRAPHY TESTING PROGRAM

Covered female subscribers age 35-39 can obtain one baseline mammogram (four-view) during those years at no cost at participating facilities throughout the state. Covered female subscribers age 40-74 can obtain one routine mammogram (four-view) a year at no cost at participating facilities throughout the state. There are no claim forms to file. A physician's referral is not required, but some facilities may ask for one. Routine mammograms are not covered at nonparticipating facilities in South Carolina and in the bordering states. Diagnostic mammograms are covered, subject to deductibles and coinsurance.

PAP TEST BENEFIT

The Plan will pay yearly for a Pap test if you are a covered woman age 18 through 65. This benefit applies whether the Pap test is routine or diagnostic. However, it does not include the office visit or other lab charges. Deductibles and coinsurance do not apply to this benefit.

MATERNITY MANAGEMENT PROGRAM

The Maternity Management Program is designed to help mothers-to-be covered by the State Health Plan receive prenatal care. The Medi-Call penalty (\$200) will apply if you fail to contact Medi-Call during the first trimester to certify your pregnancy.

COLONOSCOPIES

Subscribers age 50 and older may receive one colonoscopy every ten years even when no symptoms are apparent. The plan also covers diagnostic colonoscopies. All colonoscopies are subject to the plan's deductibles and coinsurance.

WELL CHILD CARE BENEFITS

Well Child Care benefits are free, and there are no claims to file when a doctor in the State Health Plan Physician Network provides the services. Covered dependent children, from birth through age 18, are eligible for the Well Child Care benefit. When you use a network doctor, the Well Child Care benefit pays 100 percent of the cost of covered childhood immunizations. When obtained from a network doctor, the Well Child Care benefit also provides 100 percent coverage for routine checkups at specified ages.

PREVENTIVE BENEFITS FOR SAVINGS PLAN PARTICIPANTS

Savings Plan participants are encouraged to take greater responsibility for their health. To make that easier, the plan offers additional preventive benefits at no cost. They include:

- Reimbursement for a yearly flu shot for each eligible participant
- Access to the 24-hour Health at Home[®] Nurseline, through which registered nurses provide personal, immediate assistance to subscribers
- A copy of the 416-page, full-color self-care handbook, *Health at Home[®]—Your Complete Guide to Symptoms, Solutions & Self-Care*.

Children age 18 and younger receive the Well Child Care benefits that are also offered to those enrolled in the Standard Plan. Savings Plan participants, age 19 and older, may receive from a network provider an annual physical that includes:

- A preventive, comprehensive examination
- A complete urinalysis
- An EKG
- A fecal occult blood test
- A general health laboratory panel “blood work”
- A lipid panel every five years
- A Pap test.

Note: If your network physician uses a non-network physician or laboratory provider for testing, the tests will not be covered as part of the annual physical.

PRESCRIPTION DRUG BENEFITS

The Prescription Drug Program, administered by Medco, is easy and convenient to use. Please remember, **prescription drugs are only covered at network pharmacies.**

STANDARD PLAN

You show your SHP ID card when you purchase your prescriptions from a network pharmacy and pay a copayment of either \$10 for tier 1 (generic — lowest cost) drugs, \$25 for tier 2 (brand — higher cost) or \$40 for tier 3 (brand — highest cost) medications for up to a 31-day supply. You pay the full cost of the prescription if the price is less than the copayment. Prescription drug benefits are payable without an annual deductible, and there is an annual \$2,500 copayment maximum per person.

SAVINGS PLAN

You pay the full allowable charge for your prescription drugs when you purchase them. There are no copayments. This cost is transmitted electronically to BlueCross BlueShield of South Carolina. If you have not met your annual deductible, the full allowable charge for the drug will be credited to it. If you have met your deductible, you will be reimbursed for 80 percent of the allowable charge for the drug. The remaining 20 percent of the cost of the drug will be credited to your coinsurance maximum. Non-sedating antihistamines and drugs for erectile dysfunction are not covered under the Savings Plan.

“Pay-the-Difference” Policy

Both plans have a “**pay-the-difference**” policy. This means that if you purchase a brand-name drug when an equivalent generic drug is available, the plan will only cover the cost of the generic drug. This policy will apply even if the doctor prescribes the medication as “Dispense As Written” or “Do Not Substitute.”

Under the **Standard Plan**, if you purchase a brand-name drug instead of a generic, you will be charged the generic copayment, PLUS the difference in price between the brand name and the generic drug. If this amount is less than the preferred or nonpreferred brand copayment, you will pay the applicable brand copayment. Only the copayment for the generic drug will apply toward your copayment maximum.

Under the **Savings Plan**, if you purchase a brand-name drug instead of a generic, only the allowable charge for the generic drug will apply toward your deductible. After you have met your deductible, only the allowable charge for the generic drug will apply toward your coinsurance maximum.

Prescription drugs are also available by mail at a discount. For details, see your 2008 *Insurance Benefits Guide*.

BEHAVIORAL HEALTH BENEFITS

Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and out-of-pocket maximums as medical claims. There are no caps on the number of provider visits.

If you need to see a mental health care provider when you are in or out of South Carolina, call APS Healthcare, toll-free at 800-221-8699, and you will be directed to a national network of providers.

The mental health and substance abuse provider network operates just like the physician network. The major differences are that no benefits are paid if you use a hospital or provider that does not participate in the network, and services, including hospital admissions, are covered only if they are preauthorized. The mental health and substance abuse provider network is an open network. This means that any eligible provider can participate in it. Your participating provider is responsible for submitting claims for these services, so there are no claims for you to file.

If you do not obtain preauthorization from APS, no mental health or substance abuse benefits will be paid.

To see the list of network providers, go to the APS Healthcare, Inc., Web site at www.apshealthcare.com. Click on "Information for Members" at the top of the page. Then select "State of South Carolina" from the drop-down list under "Employers." Then click on "Online Provider Locator." The access code is "statesc." Finally, click on "Submit." You may also call APS Healthcare at 800-221-8699 to be directed to a network provider and to receive the required preauthorization.

Health Maintenance Organizations

BLUECHOICE HEALTHPLAN

BlueChoice HealthPlan is a traditional HMO offered statewide.

With BlueChoice HealthPlan, you select a Primary Care Physician (PCP) to coordinate your healthcare. If you need services your PCP does not offer, he or she will refer you to a qualified specialist in the network.

See the health plan comparison chart on pages 36-37 for more information about the HMOs.

BlueChoice HealthPlan offers a wide range of programs designed to keep you healthy. Preventive care is a key feature of the plan. As a member, you simply pay a small copayment for well child visits and immunizations, as well as for any primary care visit.

For more information about BlueChoice HealthPlan, see pages 63-74 of your 2008 *Insurance Benefits Guide*.

CIGNA HMO

CIGNA HMO, a traditional HMO plan administered by CIGNA HealthCare, is available in all counties in the state **except**: Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.

With CIGNA HMO, your primary care physician (PCP) is your first and primary source of medical care. The PCP you choose coordinates your medical care, including checkups, referrals to specialists, lab and X-ray services and hospital admissions.

When you enroll in CIGNA HMO, you and each covered member of your family chooses his or her own PCP. A woman may select an OB/GYN in addition to her PCP. A PCP can be a family/general practitioner, internist or pediatrician. PCPs are available to you 24 hours a day, seven days a week. If your personal doctor is not available, he will arrange for another doctor to take care of you.

For more information about CIGNA HMO, see pages 75-78 of your 2008 *Insurance Benefits Guide*.

MUSC OPTIONS

MUSC Options is a self-insured, point of service plan.

Health claims are processed by BlueChoice HealthPlan. Pharmacy claims are processed by Medco Health Solutions, Inc.

Permanent, full-time eligible employees who live or work in Berkeley, Charleston, Colleton or Dorchester counties may enroll. The plan is also available to retirees (including those who are eligible for Medicare), survivors and COBRA subscribers who live in this area.

For more information about MUSC Options, see pages 79-92 of your 2008 *Insurance Benefits Guide*.

Dental Insurance

STATE DENTAL PLAN

The State Dental Plan is provided at no cost to active employees and funded retirees. You may add your eligible dependents for an additional premium, and they do not have to be enrolled in a state health plan. Dental plan benefits are divided into categories, or *classes*.

DENTAL PLUS

Dental Plus provides a higher level of coverage for dental services covered under the State Dental Plan. It is not an offset program that pays what the State Dental Plan does not. Instead, it covers the *same procedures and services* (except orthodontics) at the *same percentage rate of coverage* as the State Dental Plan, but at a *higher allowance* (dollar amount) for the charges. Dental Plus provides this higher level of coverage at affordable rates.

You pay Dental Plus premiums with no contribution from the state. Active employee premiums can be paid on a pretax basis through MoneyPlu\$. Dental Plus premiums are **in addition** to State Dental Plan premiums. Dental Plus subscribers are required to cover the same family members at the same level of coverage under both plans.

Under Dental Plus, reimbursement is based on what your dentist charges, up to the maximum Dental Plus allowance. The allowance is based on what most dentists in South Carolina charge for particular services. This means that your dental expenses may fall within these allowances, and you will only be responsible for paying the deductible and coinsurance. If your dentist charges more for covered services than Dental Plus allows, **you** will be responsible for paying the difference unless your dentist has agreed to accept the Dental Plus allowance.

The combined annual maximum benefit for the State Dental Plan and Dental Plus for services in classes I, II and III is \$2,000 per covered person (compared to \$1,000 with the State Dental Plan alone). There are no additional deductibles and coinsurance under Dental Plus.

Once you enroll in the State Dental Plan or Dental Plus, you may not drop that coverage until the next open enrollment period, which will be in October 2009, or until you become eligible to change your coverage due to a special eligibility situation.

YOUR DENTAL BENEFITS AT A GLANCE

Class	Services Covered	Plan	Yearly Deductible	Percent Covered	Maximum Benefit
I Diagnostic and Preventive	Diagnostic and preventive procedures Cleaning and scaling of teeth Fluoride treatment Space maintainers (child) Emergency pain relief X-rays	State Dental Plan alone	None	100% of allowed amount	\$1,000 per person each benefit year combined for Classes I, II and III
		with Dental Plus	None	100% of allowed amount or actual charge (whichever is less)	\$2,000 ² per person each benefit year combined for Classes I, II and III
II Basic Benefits	Fillings Simple extractions Oral surgery Surgical extractions Preparation of mouth for dentures Periodontal procedures	State Dental Plan alone	\$25 per person. If you have services in Classes II and III, you still pay only one deductible. Limited to three per family per year.	80% of allowed amount	\$1,000 per person each benefit year combined for Classes I, II and III
		with Dental Plus	No additional deductible	Up to 80% of allowed amount after State Dental Plan deductible is met	\$2,000 ² per person each benefit year combined for Classes I, II and III
III Prosthodontics	Onlays Crowns Bridges Dentures Repair of prosthodontic appliances	State Dental Plan alone	\$25 per person. If you have services in Classes II and III, you still pay only one deductible. Limited to three per family per year.	50% of allowed amount	\$1,000 per person each benefit year combined for Classes I, II and III
		with Dental Plus	No additional deductible	50% of allowed amount after State Dental Plan deductible is met	\$2,000 ² per person each benefit year combined for Classes I, II and III
IV Orthodontics¹	Limited to covered dependent children age 18 and under Correction of malocclusion Consisting of: diagnosis (including models and X-rays) Active treatment (including necessary appliances)	State Dental Plan alone	None	50% of allowed amount	\$1,000 lifetime benefit for each covered child
		with Dental Plus	Dental Plus does not offer orthodontia benefits.	Dental Plus does not offer orthodontia benefits.	Dental Plus does not offer orthodontia benefits.

¹ A subscriber must submit a letter from his provider for the covered dependent children age 18 and under stating that the orthodontic treatment is not for cosmetic purposes for it to be covered by the State Dental Plan.

² \$2,000 is the maximum yearly benefit an individual may receive when enrolled in both the State Dental Plan and Dental Plus.

Life Insurance (for active employees only)

BASIC LIFE INSURANCE

The Basic Life Insurance Program provides group term life and accidental death and dismemberment coverage at no cost if you are enrolled in a health plan offered by EIP. Employees under age 70 are provided with \$3,000 life insurance coverage, and employees over age 70 are provided with \$1,500 coverage. The Hartford Insurance Company administers this benefit. If you are terminating employment, you may convert your coverage to an individual policy. To do so, you must apply to The Hartford in writing within 31 days of the date your insurance under this plan ends, and you must pay the required premiums.

OPTIONAL LIFE INSURANCE

You can enroll in the Optional Life Insurance Plan within 31 days of the date you are hired. You do not have to be enrolled in health or dental coverage to participate in the Optional Life program. This policy includes life, accidental death benefits (including day care, education and felonious assault benefits), a prorated benefit for loss of certain limbs or movement abilities, a living benefit for employees under age 60, a 12-month waiver of premium for disability, and a seat belt provision, which is an additional 25 percent of your accidental death benefit (when applicable), and an air bag benefit (when applicable).

As a new employee, you can elect coverage in \$10,000 increments, up to the lesser of: three times your basic annual earnings, rounded down to the nearest \$10,000; or \$500,000, without providing medical evidence of good health. You can select a higher benefit level in increments of \$10,000, up to a maximum of \$500,000, by providing medical evidence of good health. Your coverage begins on the first day of the month coinciding with, or the first of the month after, your date of employment if you are actively at work on that day as a full-time employee. If you apply for an amount of coverage that requires medical evidence of good health, your coverage effective date will be the first of the month after approval.

If you participate in the MoneyPlu\$ Pretax Group Insurance Premium Feature (see page 26), you can increase, decrease or drop your coverage only during October enrollment periods or within 31 days of a special eligibility situation. To increase your coverage during annual enrollment, you must provide medical evidence of good health and be approved by The Hartford. If approved, coverage will be effective on January 1 after annual enrollment as long as you are actively at work on that day as a full-time employee. You can increase your coverage due to a special eligibility situation in increments of \$10,000, up to \$50,000, without providing medical evidence of good health. You can increase your coverage further *with* medical evidence. Remember that a salary increase does not constitute a special eligibility situation. If you do not participate in the MoneyPlu\$ Pretax Premium Feature, Optional Life enrollment and coverage changes are allowed year-round (subject to approval of medical evidence).

Through MoneyPlu\$, your entire Optional Life insurance premium can be deducted from your paycheck before taxes. However, only premiums for coverage up to \$50,000 will be tax exempt. Premiums paid for additional coverage (more than \$50,000) will be added back into your earnings on your W-2 form at the end of the year. Please refer to the MoneyPlu\$ section for enrollment information.

Your premiums will increase automatically each January 1 after you enter a new age bracket. When you retire, you may continue your coverage in \$10,000 increments, up to your active coverage level until age 75. Coverage is reduced at age 70 for active employees and retirees. Premiums and reduced coverage levels are on pages 39-41.

Deferred Effective Date

If you are absent from work due to a physical or mental condition on the date your insurance or your dependent's insurance would otherwise have become effective or would have been increased,

the effective date of insurance or the effective date of any increase in insurance will be deferred until the date you return to work as an active, permanent, full-time employee for one full day.

DEPENDENT LIFE INSURANCE

You do not have to be enrolled in Optional Life, health or dental coverage to enroll in the Dependent Life insurance program. Dependents can be a spouse (who must not be eligible as an employee of a participating employer) and dependent children between the ages of 14 days and 19 years, or up to age 25 if they are full-time students. A child becomes ineligible for Dependent Life coverage at age 19 if he is not a full-time student, or at a younger age if he marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support. An incapacitated child becomes ineligible if he marries or is no longer principally dependent (more than 50 percent) upon the employee for maintenance and support.

DEPENDENT LIFE — SPOUSE

Within 31 days of the date you begin employment or within 31 days of your marriage, you can enroll your spouse for up to \$20,000 in life insurance without providing medical evidence of good health. Medical evidence of good health is required for late entry for a spouse and for coverage in amounts greater than \$20,000. If you are enrolled in Optional Life, you may cover your spouse in increments of \$10,000, up to 50 percent of your Optional Life coverage or \$100,000, whichever is less.

If you are not enrolled in Optional Life, you may elect coverage for your spouse in the amount of \$10,000 or \$20,000. Premiums for Dependent Life spouse coverage, just like Optional Life premiums, are based on the **employee's** age. You pay the premium with no contribution from the state, and it is payable through payroll deduction. The employee is the beneficiary.

DEPENDENT LIFE — CHILDREN

You can enroll your eligible dependent children for \$15,000 in coverage. Medical evidence is not required to cover a child, even if the child is a late entrant. The monthly premium for Dependent Life child coverage is \$1.24, regardless of the number of children covered. You pay the entire premium with no contribution from the state, and it is payable through payroll deduction.

Your dependent's coverage will end at midnight on the earliest of:

- The date the policy ends
- The date you, the employee, are no longer eligible to purchase Dependent Life insurance coverage
- The date the dependent no longer meets the definition of a dependent or
- The date premiums for Dependent Life insurance coverage are due and unpaid for a period of 31 days.

If your dependent's coverage ends because of one of the reasons above, his coverage may be converted to an individual life insurance policy. To do so, the dependent must apply to The Hartford in writing within 31 days of the date his insurance under this plan ends and pay the required premiums for his age and class of risk.

What is the Deferred Effective Date for Dependents?

If a dependent, other than a newborn, is confined in a hospital or elsewhere* because of a physical or mental condition on the date insurance would otherwise have become effective, the effective date of insurance will be deferred until the dependent is discharged from the hospital or no longer confined and has engaged in substantially all the normal activities of a healthy person of the same age for a period of at least 15 days in a row.

** "Confined elsewhere" means the individual is unable to perform, unaided, the normal functions of daily living, or leave home or another place of residence without assistance.*

MoneyPlu\$

MoneyPlu\$ is a program that enables you to save money on eligible medical and dependent care costs by permitting you to pay these expenses with income deducted from your salary before it is taxed.

PRETAX PREMIUMS

For Active Employees: The Pretax Group Insurance Premium Feature allows you to pay your State Health Plan, HMO, State Dental Plan, Dental Plus and Optional Life (for coverage up to \$50,000) premiums before taxes are taken from your paycheck.

FLEXIBLE SPENDING ACCOUNTS

For Active Employees: MoneyPlu\$ allows you to pay eligible medical and dependent care expenses with money before it is taxed. You authorize deposits to your MoneyPlu\$ account every pay period, before your salary is taxed. As you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. There are three kinds of MoneyPlu\$ accounts: a **Medical Spending Account**, a **limited-use Medical Spending Account** that can accompany a Health Savings Account and a **Dependent Care Spending Account**. If you incur dependent care and medical expenses, you can establish both a dependent care account and a Medical Spending Account or a limited-use Medical Spending Account. *To participate in the Medical Spending Account, you must have completed one year of continuous state service by January 1 after annual enrollment.*

For more information about the EZ REIMBURSE® Card, please consult your 2008 Insurance Benefits Guide, pages 152-154.

HEALTH SAVINGS ACCOUNTS

For Active Employees and Non-Medicare Eligible Retirees: A MoneyPlu\$ Health Savings Account (HSA) is available to subscribers enrolled in the SHP Savings Plan and can be used to pay healthcare expenses. Unlike money in a MoneyPlu\$ Medical Spending Account, the funds do not have to be spent in the year they are deposited. Money in the account accumulates tax free, so the funds can be used to pay qualified medical expenses in the future. An important advantage of the HSA is that you own it. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

ADMINISTRATIVE FEES

Pretax Group Insurance Premium Feature:	\$0.28 per month ¹
Dependent Care Spending Account:	\$3.50 per month ¹
Medical Spending Account or limited-use MSA:	\$3.50 per month ¹
EZ REIMBURSE® MasterCard® Card	\$10 per year ²
Health Savings Account	\$12 per year ³ \$10 per year or \$1 per month (your choice) ⁴ 35 cents per check if you are reimbursed by check ⁵ No charge if you use your Visa® debit card.

¹ This fee is deducted from your paycheck before taxes.

² The fee for this optional card will be deducted from your Medical Spending Account at the beginning of the year.

³ This FBMC fee is deducted from your paycheck at a rate of \$1 a month.

⁴ This bank fee, which is deducted from your account, is waived if the balance in your account is over \$2,500. If you prefer to pay it annually rather than monthly, call 877-362-4472 within 60 days of opening the account.

⁵ There may be additional fees for other services. All fees are deducted from your HSA.

Disability Insurance

BASIC LONG TERM DISABILITY (BLTD)

BLTD is an employer-funded disability plan for active employees who are enrolled in a health plan offered by the Employee Insurance Program. BLTD provides a benefit of 62.5 percent of the employee's gross monthly salary, *less other sources of income*, up to a maximum benefit of \$800 per month. There is no minimum benefit if these offsets exceed 62.5 percent of the employee's gross monthly salary. BLTD has a 90-day benefit waiting period.

Upon approval, these taxable benefits are payable for up to 24 months if an employee is unable to perform the duties of his own general occupation, and up to age 65 or older, in some circumstances, if an employee is unable to perform the duties of any and all occupations which he is able to perform, due to education, training or experience. These alternative occupations must be available at one or more locations in the national economy. They must be occupations in which the employee can be expected to earn at least 65 percent of his pre-disability earnings (adjusted for inflation) within 12 months following his return to work, regardless of whether the employee is working in his previous occupation or any other occupation. In addition, there is a two-year limit on benefits for certain medical conditions.

BLTD is provided to active employees only and cannot be continued at retirement.

SUPPLEMENTAL LONG TERM DISABILITY (SLTD)

SLTD is a voluntary program in which the employee pays all premiums. This benefit pays 65 percent of the employee's gross monthly salary, *less other sources of income, including the BLTD benefit*, up to a monthly maximum of \$8,000. If these other sources of income (called "offsets") exceed 65 percent of the employee's gross monthly salary, the plan will pay a minimum of \$100 per month.

These non-taxable benefits are payable for 24 months if an employee is unable to perform the duties of his own occupation, and up to age 65 or older, in certain circumstances, if the employee is unable to perform the duties of any and all jobs which he is able to perform, due to education, training or experience. These alternate occupations must be available at one or more locations in the national economy. They must be occupations in which the employee can be expected to earn at least 65 percent of his pre-disability earnings (adjusted for inflation) within 12 months following his return to work, regardless of whether the employee is working in his previous occupation or any other occupation. In addition, there is a two-year limit on benefits for certain medical conditions.

The SLTD policy includes a "Lifetime Security Benefit." This benefit is designed to extend SLTD benefits indefinitely for a disabled person who is suffering from severe cognitive impairments or who is unable to perform two or more activities of daily living. The activities of daily living considered are bathing, continence, dressing, eating, toileting and transferring.

At enrollment, the employee may choose either a 90-day or 180-day benefit waiting period. Premiums are based on the employee's age and salary. If the employee does not enroll in SLTD within 31 days of being hired, he may apply throughout the year by providing medical evidence of good health. An employee must also provide medical evidence of good health if he chooses to change his benefit waiting period from 180 to 90 days.

Generally, you may not continue SLTD coverage in retirement. However, if you are retiring or leaving employment, but plan to be self-employed or work for an employer that does not have a supplemental long term disability program, contact Standard Insurance Company for more information about continuing coverage.

COMPARISON OF BLTD AND SLTD PROGRAMS

	BLTD	SLTD
Eligibility	Must be enrolled in a state health plan	Voluntary program
Premium payment	Employer pays monthly premium	Employee pays monthly premium
Benefit waiting period	90-day waiting period	Employee chooses 90-day or 180-day waiting period
Maximum benefit	Monthly benefit is 62.5% of gross monthly salary*: \$800 maximum with offsets	Monthly benefit is 65% of gross monthly salary*: \$8,000 maximum with offsets
Minimum benefit	No minimum monthly benefit if offsets exceed 62.5% of gross monthly salary*	\$100 per month minimum if offsets exceed liability
Taxability of Benefits	Yes	No

* Gross monthly salary is based upon the rate of pay on January 1 preceding the disabling event.

Long Term Care Insurance

Long Term Care (LTC) is the day-to-day assistance that you need when you have a serious illness or disability that lasts for an extended period of time and you are not able to take care of yourself. Long Term Care includes a wide range of services that can be provided in your home, an adult day-care center, an assisted-living facility, a nursing home or a hospice. The Employee Insurance Program and Aetna, the Long Term Care program's administrator, offer you the Long Term Care Insurance program, with three plan options that are designed to protect your assets from depletion by the costs of long term care.

Full-time, permanent employees may enroll in the LTC Insurance program within 31 days of their hire date, without providing medical evidence of good health. Current full-time, permanent employees may enroll throughout the year, with approval of medical evidence of good health. Spouses, parents and parents-in-law of eligible employees may enroll throughout the year with approval of medical evidence of good health. A spouse, parent or parent-in-law is eligible to apply for enrollment even if the employee does not enroll. There is a 10 percent discount in premiums if both an employee and spouse enroll in the Service Reimbursement plans.

There are three LTC plans from which to choose: a disability plan and two service reimbursement plans. LTC plan premiums are on pages 42-44.

LTC PLAN COMPARISON

	Disability Plan (Option #1)	Service Reimbursement Plan (Option #2)	Service Reimbursement Plan (Option #3)
Daily Benefit Amount (DBA)	\$50 - \$250 in \$10 increments	\$50 - \$350 in \$10 increments	\$50 - \$350 in \$10 increments.
Lifetime Maximum Benefit Amount	5 years x DBA	5 years x DBA	5 years x DBA
Nursing Facility or Hospice Care	You receive 100% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.
Assisted Living Facility Care	You receive 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.
Community-Based Services	You receive 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.
Informal Care	You receive 50% of your Daily Benefit Amount.	25% of your Daily Benefit Amount up to 100 days each calendar year. ¹	25% of your Daily Benefit Amount up to 50 days each calendar year. ¹
Alternate Care	You receive 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 100% of your Daily Benefit Amount.
Transitional Care	You receive 50% of your Daily Benefit Amount.	You receive 3 times your Daily Benefit Amount. ²	You receive 3 times your Daily Benefit Amount. ²
Caregiver Training	You receive 50% of your Daily Benefit Amount.	You receive the lesser of 100% of the actual expenses or 3 times your DBA. ¹	You receive the lesser of 100% of the actual expenses or 3 times your DBA. ¹
Respite Care	You receive 50% of your Daily Benefit Amount.	You receive your actual expenses, up to 50% of your Daily Benefit Amount for 21 days each calendar year. ¹	You receive your actual expenses, up to 100% of your Daily Benefit Amount for 21 days each calendar year. ¹

¹Not subject to lifetime maximum.

²Not subject to lifetime maximum, paid only once in a lifetime.

Late Entry and Making Coverage Changes

HEALTH PLANS

If you and/or any of your eligible dependents do not enroll in the State Health Plan or an HMO within 31 days of eligibility, you will be considered a late entrant. You must wait until the next open enrollment period, held in October of odd-numbered years, or a special eligibility situation, to enroll.

Enrollment and changes not made within 31 days of the date of hire or a special eligibility situation cannot be made until the next open enrollment period or within 31 days of the next special eligibility situation. Coverage will be effective the following January 1 for changes made during open enrollment. Late entrants are subject to an 18-month pre-existing condition exclusion period (see page 11).

DENTAL PLANS

If you and/or any of your eligible dependents do not enroll in the State Dental Plan or Dental Plus within 31 days of eligibility, you must wait to enroll until the next open enrollment period or special eligibility situation. Coverage will be effective the following January 1 for changes made during open enrollment.

LIFE INSURANCE

If you do not participate in the MoneyPlu\$ Pretax Premium Feature and do not enroll within 31 days of the date you begin employment, you can enroll in Optional Life throughout the year as long as you provide medical evidence of good health and it is approved by The Hartford. To enroll, you must complete an NOE and a Personal Health Application and return these forms to your benefits office. If approved, coverage will be effective the first of the month after approval, subject to the deferred effective date provision (see page 24). If you participate in the MoneyPlu\$ Pretax Group Insurance Premium Feature, you may enroll only within 31 days of a special eligibility situation or during the annual enrollment period. (Approval of medical evidence will be required, and coverage will be effective the following January 1.)

If you do not enroll your dependent spouse in the Dependent Life Insurance program within 31 days of your date of hire or a special eligibility situation, you can apply throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval. You can enroll your dependent child at any time without medical evidence of good health. The deferred effective date provision applies to these coverage increases (see pages 24 and 25).

SUPPLEMENTAL LONG TERM DISABILITY

If you do not enroll in the Supplemental Long Term Disability (SLTD) program when first eligible, or wish to decrease your benefit waiting period from 180 days to 90 days, you can do so throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval.

LONG TERM CARE

If you do not enroll in the LTC program when first eligible, or you wish to increase your coverage, you can apply throughout the year by providing medical evidence of good health. If approved, coverage will be effective the first of the month after approval. Your spouse, parents and parents-in-law may enroll throughout the year with approval of medical evidence of good health.

SPECIAL ELIGIBILITY SITUATIONS

Coverage changes allowed due to a special eligibility situation must be made within 31 days of the date of occurrence. Special eligibility situations include:

- Marriage
- Birth, adoption or placement for adoption
- Custody or guardianship
- Divorce, annulment, separation, court order
- Spouse becomes a state employee
- Gain or loss of other coverage
- Spouse retires
- Child turns age 19 and is not a full-time student
- Child age 19 through 24 becomes a full-time student
- Child is a full-time student who turns age 25
- Child becomes incapacitated before age 19 or before age 25 if a full-time student
- Death of a covered dependent and
- Child marries or is no longer principally dependent (more than 50 percent) on the employee for support and maintenance.

SPECIAL ELIGIBILITY SITUATIONS AND OPTIONAL LIFE INSURANCE

Employees participating in the MoneyPlu\$ Pretax Group Insurance Premium Feature are subject to MoneyPlu\$ regulations and must make all requests within 31 days of a special eligibility situation or wait until an annual enrollment period to make changes.

Employees **not** participating in the MoneyPlu\$ Pretax Group Insurance Premium Feature may add Optional Life or increase the level of coverage year-round by providing medical evidence of good health, subject to the deferred effective date provision (see page 24). Employees not participating in the MoneyPlu\$ Pretax Group Insurance Premium Feature may cancel Optional Life coverage or decrease the level of coverage effective the first of the month after the request.

CHANGES YOU MAY MAKE THROUGHOUT THE YEAR

ADDING/CHANGING COVERAGE

You may enroll yourself and any eligible dependents in a health and/or dental plan within 31 days of marriage, birth, adoption or placement for adoption. For other special eligibility situations, you may enroll only those dependents for whom the situation applies; you may not enroll other dependents for whom there is no special eligibility situation. You must submit an NOE and documentation within 31 days of the event. Changes not made within 31 days of the special eligibility situation may not be made until the next open enrollment period or special eligibility situation.

You may enroll yourself and/or your spouse in the Long Term Care (LTC) Insurance program, or increase your coverage level, upon approval of medical evidence of good health.

You may enroll in Supplemental Long Term Disability (SLTD) coverage or change from a 180-day waiting period to a 90-day waiting period with approval of medical evidence of good health.

DECREASING COVERAGE

You may decrease your coverage level for health and/or dental if a spouse or dependent child becomes ineligible. Reasons for ineligibility include: spousal divorce or separation; child turns age 19 and is not a full-time student; child turns age 25, child marries or is no longer principally dependent (more than 50 percent) on the employee for maintenance and support; or gain of other coverage. Changes should be requested within 31 days of ineligibility. You can drop SLTD coverage throughout the year.

Tips for Completing the NOE

Notice of Election (NOE) forms are available on the EIP Web site at www.eip.sc.gov. The NOE form is used to enroll in benefits; add or delete dependents; or change a subscriber's coverage level, beneficiary, name or address.

You may complete an NOE in one of two ways:

- **Interactively*** — Type information directly into the spaces provided, print the completed form, sign it and submit it to your benefits administrator. Be careful to click on only one box or selection when only one choice is allowed (such as choice of health plan).
- **Manually** — Print the form, fill it out by hand and submit it. If your BA can submit your NOE electronically, he will let you know before you fill it out.

Your benefits administrator will let you know if he will be enrolling you through an online enrollment system.

* If you have Internet access, you are encouraged to use the interactive NOE on the EIP Web site. However, for those who do not have access to the Web, printed NOEs are available from your benefits administrator.

GENERAL TIPS

- Fill out the NOE completely if you are enrolling as a new employee.
- Mark only the benefits in which you are enrolling.
- Review the NOE for accuracy, required documentation and for your signature.
- If you have any questions about completing the form, refer to the instructions on page 2 of the form or ask your benefits administrator.

1. ADMINISTRATIVE INFORMATION

Complete the information, except for the block "BA USE ONLY." Be sure to check "Y" or "N" in the MoneyPlus block to indicate whether you want your health, dental and/or Optional Life insurance premiums to be deducted from your paycheck on a pretax basis.

2. ENROLLEE INFORMATION

Complete all relevant information, including your phone number at work and an e-mail address if you have one.

- If you are completing the form online, a scrolling list of county code numbers appears for box #17. If you are completing the form manually, check with your benefits administrator for the correct county code number.

3. MEDICARE

This information will be used to determine eligibility for enrolling in the Savings Plan as well as for coordination of benefits, including prescription drug benefits.

- **MEDICARE PART A AND/OR PART B.** List yourself and any other covered dependents who are eligible for Part A or Part B of Medicare and check the reason for eligibility.

(tips continued on page 34)

Sample Notice of Election Form (NOE)

Page 1

REFRESH

South Carolina State Budget and Control Board Employee Insurance Program Active Notice of Election (NOE)

1	ADM INFO	Check One: <input type="checkbox"/> New Hire <input type="checkbox"/> Transfer <input type="checkbox"/> Change		Type of Change <input type="checkbox"/> Enrollment <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Address Date of Occurrence: _____		BA Use Only Effective Date: _____ Group ID#: _____ Group Name: _____		MoneyPlus <input type="checkbox"/> Yes <input type="checkbox"/> No Health Savings Account <input type="checkbox"/> Yes <input type="checkbox"/> No (For Use with Savings Plan)									
		1. Social Security Number		2. Last Name		3. Suffix		4. First Name		5. M.I.		6. Date of Birth MM/DD/YYYY					
2	ENROLLEE INFO	7. Sex <input type="checkbox"/> M <input type="checkbox"/> F		8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		9. Home Phone # ()		10. Work Phone # ()		11. E-mail Address					
		12. Mailing Address		13. Apt.		14. City		15. State SC		16. Zip Code		17. County Code		18. Annual Salary		19. Date of Hire MM/DD/YYYY	
3	MEDICARE	LIST BELOW, YOURSELF AND ANY OTHER PERSONS TO BE COVERED WHO ARE ELIGIBLE FOR PART A AND/OR PART B OF MEDICARE.															
		20. NAME		MEDICARE#		ENTITLED DUE TO				EFFECTIVE DATE							
						<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease				PART A MM/DD/YYYY							
4	BENEFITS	21. HEALTH PLAN (Refuse or select one plan and one category) PLAN <input type="checkbox"/> Standard <input type="checkbox"/> HMO <input type="checkbox"/> Refuse <input type="checkbox"/> Savings (Non-Medicare) Name of HMO _____ CATEGORY <input type="checkbox"/> Enrollee <input type="checkbox"/> Enrollee/Child(ren) <input type="checkbox"/> Enrollee/Spouse <input type="checkbox"/> Family															
		22. STATE DENTAL PLAN (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Enrollee <input type="checkbox"/> Enrollee/Spouse <input type="checkbox"/> Enrollee/Child(ren) <input type="checkbox"/> Family				23. DENTAL PLUS (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Yes											
		24. DEPENDENT LIFE - Child(ren) (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> \$15,000		25. DEPENDENT LIFE - Spouse (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Coverage Level \$ _____ (Must be in increments of \$10,000)		26. OPTIONAL LIFE (Select One) <input type="checkbox"/> Refuse <input type="checkbox"/> Coverage Level \$ _____ (Must be in increments of \$10,000)		27. SUPPLEMENTAL LTD (Select One) <input type="checkbox"/> Refuse/Cancel <input type="checkbox"/> Plan One - 90 day benefit waiting period <input type="checkbox"/> Plan Two - 180 day benefit waiting period		28. BASIC LIFE/BASIC LTD Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.							
5	BENEFICIARIES INFO	In blocks 29, 30 and 31, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.															
		Basic Life or Optional Life (Check one or both) <input type="checkbox"/> Basic Life <input type="checkbox"/> Optional Life		29. SSN#		Last Name		First Name		Relationship		Date of Birth MM/DD/YYYY		Primary or Contingent			
6	DEPENDENT INFORMATION	If Beneficiary is an organization or trust, complete the following: Organization/Trust _____ Address _____ If Trust, Date signed _____															
		List spouse and eligible children to be covered. If they are not listed, they will not be covered. Is your spouse a state employee or retiree? <input type="checkbox"/> YES <input type="checkbox"/> NO															
		Add (A) or Delete (D)		30. Dependent SSN#		Last Name		First Name		SEX M/F		Relationship		Date of Birth MM/DD/YYYY		Indicate Status	
		Spouse												Spouse employed by state covered entity <input type="checkbox"/> Yes <input type="checkbox"/> No			
		Child												<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated			
		Child												<input type="checkbox"/> Full-time student <input type="checkbox"/> Incapacitated			
7	CERTIFICATION & AUTHORIZATION	31. Does your dependent(s) have other health coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO Does this coverage include pharmacy benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO If you and/or your dependents have had other coverage with another carrier within 62 days of this request, please attach a copy of your certificate of health coverage. This will ensure proper credit for any pre-existing conditions, if applicable.															
		DEPENDENT NAME		INSURANCE COMPANY		POLICY HOLDER DATE OF BIRTH		EFFECTIVE DATE OF POLICY		TERMINATION DATE (If Applicable)							
7	CERTIFICATION & AUTHORIZATION	32. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided social security numbers and documentation establishing my dependent(s) eligibility for the plan(s) selected. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period every two years. Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period every two years unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits. DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES WHETHER WRITTEN OR ORAL WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THE PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.															
		Employee Signature _____ Date _____ 33. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, form is complete and accurate and all required documentation is attached to process NOE form. Benefits Administrator Signature _____ Date _____															

EIP REV. 9/07

ORIGINAL TO EIP

COPY TO EMPLOYEE

Sample Notice of Election Form (NOE)

Page 2

EMPLOYEE INSURANCE PROGRAM INSTRUCTIONS FOR ACTIVE NOTICE OF ELECTION

IF COMPLETING BY HAND, USE BLACK INK

ADMINISTRATIVE INFORMATION: Indicate type of action to be taken. **MONEYPLUS:** Premiums for health/dental and optional life are deducted on a pretax basis. There is an administrative fee for the pretax deductions. MoneyPlus changes are limited by IRS restrictions and must be made during enrollment or within 31 days of the date of occurrence of a qualifying change in family status. **HEALTH SAVINGS ACCOUNT:** To be used with Savings Plan and is governed by IRS regulations.

ENROLLEE INFORMATION: Blocks 1-19 must be completed for all transactions, including a refusal.

MEDICARE: Block 20. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

BENEFITS: Alterations in this section are not allowed.

Block 21. HEALTH: Prior to making a health plan selection, refer to the plan descriptions provided by your employer.

To decline health coverage, check "Refuse." If you refuse health coverage or fail to enroll all eligible dependents when first eligible, you can apply for coverage for yourself and/or your dependent(s) only during an announced open enrollment period every two years. If health coverage is refused, benefits for Basic Life and Basic LTD are forfeited.

To select a health plan, check only one block.

To select a category, check only one block. In order for dependent(s) to be covered, they must be listed in Block 30, and the appropriate category must be selected.

Block 22. DENTAL: To decline dental coverage, check "Refuse." If you refuse dental now, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period every two years.

To select coverage, check only one block. In order for dependents to be covered, they must be listed in Block 30, and the appropriate category must be selected.

Block 23. DENTAL PLUS: To select Dental Plus coverage, check "yes;" to refuse coverage, select "refuse." You must enroll in the State Dental Plan to enroll in Dental Plus. Coverage level in Dental Plus must equal coverage level in State Dental Plan.

Block 24. DEPENDENT LIFE—CHILD(REN): To decline or cancel coverage, check "Refuse." To select coverage, check block. In order for dependents to be covered, they must be listed in Block 30.

Block 25. DEPENDENT LIFE—SPOUSE: Prior to making a selection, refer to the detailed instructions provided by your employer.

To decline or cancel coverage, check "Refuse." To select coverage, check block and enter coverage level for your spouse based on your current level of Optional Life and/or approved medical evidence of good health. In order for your spouse to be covered, he/she must be listed in Block 30.

Block 26. OPTIONAL LIFE: Prior to making a selection, refer to the detailed instructions provided by your employer.

To decline coverage or cancel coverage, check "Refuse." To select coverage, check block and enter coverage level. Coverage

level may be based on your current salary (newly enrolled), a guaranteed issue and/or approved medical evidence of good health. If you do not enroll within 31 days of your date of hire, medical evidence of good health must be provided and approved to enroll or increase coverage level. However, if enrolled in the MoneyPlus pretax premium feature, you must wait until the next announced enrollment period or within 31 days of a special eligibility situation.

Block 27. SUPPLEMENTAL LONG TERM DISABILITY: Prior to making a selection, refer to the detailed instructions provided by your employer.

To decline coverage or cancel coverage, check "Refuse." To select coverage, check only one block. If changing from "Plan Two" to "Plan One," medical evidence of good health must be provided.

Block 28. BASIC LIFE AND BASIC LTD: Automatically provided with health coverage. If health coverage is refused, benefits are forfeited.

BENEFICIARIES INFORMATION: Block 29. List a beneficiary for Basic Life if enrolled in health coverage and Optional Life if selected. Multiple beneficiaries may be listed. Beneficiaries must be listed individually by a given name or organization. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named survivors. Contingent beneficiaries have no rights, unless all primary beneficiaries have died.

DEPENDENT INFORMATION: Block 30. If you select a category with spouse/dependent child(ren), they must be listed to be covered. A spouse can only be covered as a dependent if not a state employee. A state employee is defined as an employee of a state agency, public school district, county, municipality, local subdivision or other entity participating in the State of South Carolina Insurance Benefits Program. If spouse is a State employee or is employed at a state covered entity, check "yes." Legal documentation is required for all children other than natural children (i.e., grandchild, niece, nephew, foster child, brother, sister, adopted child). In order for a child, age 19 through 24, to be considered eligible for coverage, the dependent must be a full-time student or incapacitated (documentation required for both). Full-time student status is subject to audits. Misstatements on the NOE may result in coverage termination and recoupment of benefits paid on behalf of the ineligible dependent.

Block 31. If you checked "yes," list all dependents with other group coverage. If you are submitting an update because a dependent no longer has other group health coverage, check "no" and list the termination date of the policy.

CERTIFICATION AND AUTHORIZATION: Form must be signed and dated by employee within 31 days of hire or the qualifying event.

Benefits Administrator must sign and date form and attach all supporting documentation prior to submitting it to the Employee Insurance Program at P.O. Box 11661 Columbia, SC 29211-1661.

Tips for Completing the NOE (continued)

4. BENEFITS

- You select or refuse your plans and coverage in this section.
- If you choose an **HMO** (with or without the point-of-service option), write the full name of the HMO: *BlueChoice HealthPlan*, *CIGNA HMO* or *MUSC Options*. The HMO that you choose will work directly with you in designating a primary care physician.
- You may enroll in **Optional Life** for up to three times your salary, rounded down to the nearest \$10,000. You may also enroll for additional coverage by providing medical evidence of good health. If you choose to enroll for more than three times your salary, you will need to complete a separate NOE indicating your chosen level of coverage and a Personal Health Application from The Hartford. The Personal Health Application is available on the EIP Web site at www.eip.sc.gov or from your benefits administrator.

5. BENEFICIARIES INFORMATION

In this section, you designate any beneficiaries to receive your life insurance in the event of your death. If more than one beneficiary is designated, they will share equally unless you specify otherwise by indicating percentages for each.

- Indicate whether they are primary beneficiaries or contingent beneficiaries. Contingent beneficiaries are paid only if any and all primary beneficiaries predecease the employee.
- If you are naming an organization or trust as beneficiary, you must complete the additional information requested.

6. DEPENDENT AND OTHER COVERAGE INFORMATION

- A checkbox is located at the start of this section to indicate whether your spouse is also employed by a participating employer.
- Be sure to **include the dependent's Social Security Number**.
- Indicate whether any dependent child who is older than 19 is a full-time student or is incapacitated and attach the appropriate documentation as required, such as a letter of certification from the academic institution or an Incapacitated Child Certification Form.
- Indicate if your dependent(s) have other group health coverage, including pharmacy benefits. Attach a list of any covered dependents who have other group health insurance coverage. This information is used for coordination of benefits and for updating EIP's records if a dependent has terminated other coverage. For example, if a dependent child has terminated other group coverage, you should indicate the termination date.

If you or your dependents had other coverage within 62 days of the effective date of coverage indicated on the NOE, attach a certificate of coverage from the previous insurer to offset any pre-existing condition exclusions.

7. CERTIFICATION & AUTHORIZATION

Read the certification and authorization before you sign the form. Return the completed form to your benefits administrator.

Comparison of Health Plan

Plan	SHP Savings Plan		SHP Standard Plan ²		
Availability	Coverage worldwide		Coverage worldwide		
Active Employee Monthly Premiums <i>Employee Only</i> <i>Employee/Spouse</i> <i>Employee/Children</i> <i>Full Family</i>	\$ 9.28		\$ 93.46		
	\$ 72.56		\$237.50		
	\$ 20.28		\$142.46		
	\$108.56		\$294.58		
	Please note that premiums for optional employer groups, such as local				
Annual Deductible <i>Single</i> <i>Family</i>	(no per-occurrence deductibles) \$3,000 \$6,000³		\$350 \$700		
Coinsurance	In-network Plan pays 80% You pay 20%	Out-of-network Plan pays 60% You pay 40%	In-network Plan pays 80% You pay 20%	Out-of-network Plan pays 60% You pay 40%	
Coinsurance Maximum <i>Single</i> <i>Family</i>	\$2,000 \$4,000 (excludes deductible)	\$4,000 \$8,000 (excludes deductible)	\$2,000 \$4,000 (excludes deductible)	\$4,000 \$8,000 (excludes deductible)	
Physicians Office Visits	Chiropractic payments limited to \$500 a year, per person		\$10 per-occurrence deductible, then:		
	No per-occurrence deductible				
	In-network Plan pays 80% You pay 20%	Out-of-network Plan pays 60% You pay 40%	In-network Plan pays 80% You pay 20%	Out-of-network Plan pays 60% You pay 40%	
Hospitalization/ Emergency Care	No per-occurrence deductibles or copays		Outpatient hospital: \$75 per-occurrence deductible Emergency care: \$125 per-occurrence deductible		
Prescription Drugs	Participating pharmacies and mail order only: You pay the State Health Plan's allowable charge until the annual deductible is met. Afterward, the Plan will reimburse 80% of the allowable charge; you pay 20%. When coinsurance maximum is reached, the Plan will reimburse 100% of the allowable charge.		Participating pharmacies only (up to 31-day supply): \$10 tier 1 (generic—lowest cost), \$25 tier 2 (brand—higher cost), \$40 tier 3 (brand—highest cost) Mail order (up to 90-day supply): \$25 tier 1, \$62 tier 2, \$100 tier 3 Copay max: \$2,500		

¹ This table is for comparison purposes only.

² Refer to the Retirement/Disability Retirement chapter in your 2008 Insurance Benefits Guide for information on how this plan coordinates with Medicare.

Benefits Offered for 2008¹

	BlueChoice HealthPlan of South Carolina ²	CIGNA HMO ²	MUSC Options ²	
	Available in all South Carolina counties Coverage worldwide	Available in all South Carolina counties except : <i>Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda</i>	Available only in these South Carolina counties: <i>Berkeley, Charleston, Colleton and Dorchester</i>	
	\$129.60 \$380.50 \$282.14 \$566.48	\$136.30 \$390.94 \$288.66 \$577.34	\$194.82 \$508.68 \$345.76 \$644.66	
subdivisions, may vary. <u>To verify your rates, contact your benefits office.</u>				
	\$250 \$500	NONE	In-network NONE	Out-of-network \$500 \$1,500
	HMO pays 90% after copays You pay 10%	HMO pays 80% after copays You pay 20%	Plan pays 100% after copays	Plan pays 60% of allowable charge You pay 40%
	\$1,500 \$3,000 (excludes deductible)	\$2,000 \$4,000 (includes inpatient, outpatient, copays and coinsurance)	N/A	\$3,000 \$9,000 (excludes deductible)
	\$15 PCP copay \$15 OB/GYN well-woman exam \$30 specialist copay	\$15 PCP copay \$15 OB/GYN exam \$30 specialist copay	\$25 PCP copay; \$25 OB/GYN well-woman exam; \$50 specialist copay	Plan pays 60% of allowable amount after annual deductible You pay 40%. No preventive care benefits out-of-network
	Inpatient: \$200 copay Outpatient: \$100 copay/first 3 visits Emergency care: \$125 copay HMO pays 90% after copays You pay 10% \$35 urgent care copay, then HMO pays 100%	Inpatient: \$500 copay per admission. Then HMO pays 80% after copays Outpatient facility: \$250 copay per admission. Then HMO pays 80% after copays Emergency care: \$100 copay. Then HMO pays 100%	Inpatient: \$300 copay Outpatient facility: \$100⁴ copay Emergency Care: \$150 copay; Urgent care: \$50 copay	Plan pays 60% of allowable charge after annual deductible You pay 40% Emergency care: \$150 copay
	Participating pharmacies only (31-day supply): \$7 generic, \$35 preferred brand, \$55 non-preferred brand, \$100 specialty pharmaceuticals Mail order (Up to 90-day supply): \$14 generic, \$70 preferred brand, \$110 non-preferred brand	Participating pharmacies only (up to 30-day supply): \$7 generic, \$25 preferred brand, \$50 non-preferred brand Mail order (up to 90-day supply): \$14 generic, \$50 preferred brand, \$100 non-preferred brand	Participating pharmacies only (up to 30-day supply): \$100 deductible, then: \$10 tier 1 (generic—lowest cost), \$30 tier 2 (brand—higher cost), \$50 tier 3 (brand—highest cost), \$100 specialty pharmaceuticals Mail order (up to 90-day supply): \$25 tier 1, \$75 tier 2, \$125 tier 3	

³ If more than one family member is covered, no family member will receive benefits, other than preventive, until the \$6,000 annual family deductible is met.

⁴ There is no copayment for services performed at MUSC outpatient facilities.

2008 Premiums

2008 MONTHLY EMPLOYER CONTRIBUTIONS¹

EMPLOYER				
	Health	Dental	Life	LTD
Employee Only	\$260.90	\$11.71	\$0.35	\$3.23
Employee/Spouse	\$514.70	\$11.71	\$0.35	\$3.23
Employee/Child	\$369.14	\$11.71	\$0.35	\$3.23
Full Family	\$602.56	\$11.71	\$0.35	\$3.23

¹Rates for employers of local subdivisions may vary. To verify your employer's rates, contact your benefits office.

2008 ACTIVE EMPLOYEE MONTHLY PREMIUMS²

HEALTH EMPLOYEE					
	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	MUSC Options
Employee Only	\$9.28	\$93.46	\$129.60	\$136.30	\$194.82
Employee/Spouse	\$72.56	\$237.50	\$380.50	\$390.94	\$508.68
Employee/Child	\$20.28	\$142.46	\$282.14	\$288.66	\$345.76
Full Family	\$108.56	\$294.58	\$566.48	\$577.34	\$644.66

²Rates for employees of local subdivisions may vary. To verify your rates, contact your benefits office.

2008 ACTIVE EMPLOYEE MONTHLY DENTAL PREMIUMS

DENTAL EMPLOYEE		
	Basic	Dental Plus
Employee Only	\$0.00	\$20.60
Employee/Spouse	\$7.64	\$39.00
Employee/Child	\$13.72	\$42.56
Full Family	\$21.34	\$60.96

2008 SUPPLEMENTAL LTD MONTHLY PREMIUM RATE

SUPPLEMENTAL LTD			STEPS TO CALCULATE SLTD MONTHLY PREMIUM
AGE	90 DAY	180 DAY	
< 31	0.00065	0.00050	1. Always select floating decimal (F) on your calculator.
31 - 40	0.00089	0.00069	2. Divide gross annual salary by 12 to determine monthly salary.
41 - 50	0.00179	0.00137	3. Multiply monthly salary by rate factor from table.
51 - 60	0.00360	0.00277	4. Drop digits to right of 2 decimal places; do not round.
61 - 65	0.00433	0.00333	5. If number is even, this is the monthly premium.
> 65	0.00528	0.00406	6. If number is odd, add .01, this is the monthly premium.

2008 MONEYPLUS MONTHLY ADMINISTRATIVE FEES

Pretax Group Insurance Premium Feature ¹	\$0.28 per month
Dependent Care Spending Account ¹	\$3.50 per month
Medical Spending Account or Limited-Use MSA ¹	\$3.50 per month
EZ REIMBURSE® Card ²	\$10 per year

Health Savings Account ¹ (fee charged by FBMC)	\$1 per month
Health Savings Account ³ (account fee charged by NBSC). This fee is waived for accounts with balances of \$2,500 or more.	\$10 per year or \$1 per month (your choice)
Reimbursement by check	\$0.35 per check ³
Use of your Visa® debit card	\$0.00

¹These fees are deducted from your paycheck before taxes.

²The fee for this optional debit card will be deducted from your Medical Spending Account.

³There may be additional fees for other services. All fees are deducted from your HSA.

2008 OPTIONAL LIFE, DEPENDENT LIFE SPOUSE MONTHLY PREMIUMS MONTHLY RATES FOR EMPLOYEES THROUGH AGE 69

Employee's Age*								
	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
Coverage								
\$10,000	\$0.68	\$0.80	\$1.26	\$1.76	\$2.74	\$4.28	\$6.56	\$9.78
\$20,000	\$1.36	\$1.60	\$2.52	\$3.52	\$5.48	\$8.56	\$13.12	\$19.56
\$30,000	\$2.04	\$2.40	\$3.78	\$5.28	\$8.22	\$12.84	\$19.68	\$29.34
\$40,000	\$2.72	\$3.20	\$5.04	\$7.04	\$10.96	\$17.12	\$26.24	\$39.12
\$50,000	\$3.40	\$4.00	\$6.30	\$8.80	\$13.70	\$21.40	\$32.80	\$48.90
\$60,000	\$4.08	\$4.80	\$7.56	\$10.56	\$16.44	\$25.68	\$39.36	\$58.68
\$70,000	\$4.76	\$5.60	\$8.82	\$12.32	\$19.18	\$29.96	\$45.92	\$68.46
\$80,000	\$5.44	\$6.40	\$10.08	\$14.08	\$21.92	\$34.24	\$52.48	\$78.24
\$90,000	\$6.12	\$7.20	\$11.34	\$15.84	\$24.66	\$38.52	\$59.04	\$88.02
\$100,000	\$6.80	\$8.00	\$12.60	\$17.60	\$27.40	\$42.80	\$65.60	\$97.80
\$110,000	\$7.48	\$8.80	\$13.86	\$19.36	\$30.14	\$47.08	\$72.16	\$107.58
\$120,000	\$8.16	\$9.60	\$15.12	\$21.12	\$32.88	\$51.36	\$78.72	\$117.36
\$130,000	\$8.84	\$10.40	\$16.38	\$22.88	\$35.62	\$55.64	\$85.28	\$127.14
\$140,000	\$9.52	\$11.20	\$17.64	\$24.64	\$38.36	\$59.92	\$91.84	\$136.92
\$150,000	\$10.20	\$12.00	\$18.90	\$26.40	\$41.10	\$64.20	\$98.40	\$146.70
\$160,000	\$10.88	\$12.80	\$20.16	\$28.16	\$43.84	\$68.48	\$104.96	\$156.48
\$170,000	\$11.56	\$13.60	\$21.42	\$29.92	\$46.58	\$72.76	\$111.52	\$166.26
\$180,000	\$12.24	\$14.40	\$22.68	\$31.68	\$49.32	\$77.04	\$118.08	\$176.04
\$190,000	\$12.92	\$15.20	\$23.94	\$33.44	\$52.06	\$81.32	\$124.64	\$185.82
\$200,000	\$13.60	\$16.00	\$25.20	\$35.20	\$54.80	\$85.60	\$131.20	\$195.60
\$210,000	\$14.28	\$16.80	\$26.46	\$36.96	\$57.54	\$89.88	\$137.76	\$205.38
\$220,000	\$14.96	\$17.60	\$27.72	\$38.72	\$60.28	\$94.16	\$144.32	\$215.16
\$230,000	\$15.64	\$18.40	\$28.98	\$40.48	\$63.02	\$98.44	\$150.88	\$224.94
\$240,000	\$16.32	\$19.20	\$30.24	\$42.24	\$65.76	\$102.72	\$157.44	\$234.72
\$250,000	\$17.00	\$20.00	\$31.50	\$44.00	\$68.50	\$107.00	\$164.00	\$244.50

Employee's Age*								
	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
Coverage								
\$260,000	\$17.68	\$20.80	\$32.76	\$45.76	\$71.24	\$111.28	\$170.56	\$254.28
\$270,000	\$18.36	\$21.60	\$34.02	\$47.52	\$73.98	\$115.56	\$177.12	\$264.06
\$280,000	\$19.04	\$22.40	\$35.28	\$49.28	\$76.72	\$119.84	\$183.68	\$273.84
\$290,000	\$19.72	\$23.20	\$36.54	\$51.04	\$79.46	\$124.12	\$190.24	\$283.62
\$300,000	\$20.40	\$24.00	\$37.80	\$52.80	\$82.20	\$128.40	\$196.80	\$293.40
\$310,000	\$21.08	\$24.80	\$39.06	\$54.56	\$84.94	\$132.68	\$203.36	\$303.18
\$320,000	\$21.76	\$25.60	\$40.32	\$56.32	\$87.68	\$136.96	\$209.92	\$312.96
\$330,000	\$22.44	\$26.40	\$41.58	\$58.08	\$90.42	\$141.24	\$216.48	\$322.74
\$340,000	\$23.12	\$27.20	\$42.84	\$59.84	\$93.16	\$145.52	\$223.04	\$332.52
\$350,000	\$23.80	\$28.00	\$44.10	\$61.60	\$95.90	\$149.80	\$229.60	\$342.30
\$360,000	\$24.48	\$28.80	\$45.36	\$63.36	\$98.64	\$154.08	\$236.16	\$352.08
\$370,000	\$25.16	\$29.60	\$46.62	\$65.12	\$101.38	\$158.36	\$242.72	\$361.86
\$380,000	\$25.84	\$30.40	\$47.88	\$66.88	\$104.12	\$162.64	\$249.28	\$371.64
\$390,000	\$26.52	\$31.20	\$49.14	\$68.64	\$106.86	\$166.92	\$255.84	\$381.42
\$400,000	\$27.20	\$32.00	\$50.40	\$70.40	\$109.60	\$171.20	\$262.40	\$391.20
\$410,000	\$27.88	\$32.80	\$51.66	\$72.16	\$112.34	\$175.48	\$268.96	\$400.98
\$420,000	\$28.56	\$33.60	\$52.92	\$73.92	\$115.08	\$179.76	\$275.52	\$410.76
\$430,000	\$29.24	\$34.40	\$54.18	\$75.68	\$117.82	\$184.04	\$282.08	\$420.54
\$440,000	\$29.92	\$35.20	\$55.44	\$77.44	\$120.56	\$188.32	\$288.64	\$430.32
\$450,000	\$30.60	\$36.00	\$56.70	\$79.20	\$123.30	\$192.60	\$295.20	\$440.10
\$460,000	\$31.28	\$36.80	\$57.96	\$80.96	\$126.04	\$196.88	\$301.76	\$449.88
\$470,000	\$31.96	\$37.60	\$59.22	\$82.72	\$128.78	\$201.16	\$308.32	\$459.66
\$480,000	\$32.64	\$38.40	\$60.48	\$84.48	\$131.52	\$205.44	\$314.88	\$469.44
\$490,000	\$33.32	\$39.20	\$61.74	\$86.24	\$134.26	\$209.72	\$321.44	\$479.22
\$500,000	\$34.00	\$40.00	\$63.00	\$88.00	\$137.00	\$214.00	\$328.00	\$489.00

* Premiums for the spouse's coverage will be based on the employee's age. Spouse coverage cannot exceed 50% of the employee's Optional Life coverage or \$100,000, whichever is less.

MONTHLY RATES FOR EMPLOYEES AGE 70 AND OLDER

Coverage	Coverage	Ages 70 - 74	Coverage	Ages 75 - 79	Coverage	Ages 80+
\$10,000	\$6,500	\$10.28	\$4,200	\$10.80	\$3,170	\$13.62
\$20,000	\$13,000	\$20.54	\$8,400	\$21.60	\$6,340	\$27.26
\$30,000	\$19,500	\$30.80	\$12,600	\$32.40	\$9,510	\$40.90
\$40,000	\$26,000	\$41.08	\$16,800	\$43.20	\$12,680	\$54.52
\$50,000	\$32,500	\$51.36	\$21,000	\$54.00	\$15,850	\$68.16
\$60,000	\$39,000	\$61.62	\$25,200	\$64.80	\$19,020	\$81.80
\$70,000	\$45,500	\$71.90	\$29,400	\$75.62	\$22,190	\$95.42
\$80,000	\$52,000	\$82.16	\$33,600	\$86.42	\$25,360	\$109.06
\$90,000	\$58,500	\$92.42	\$37,800	\$97.22	\$28,530	\$122.68
\$100,000	\$65,000	\$102.70	\$42,000	\$108.02	\$31,700	\$136.30
\$110,000	\$71,500	\$112.98	\$46,200	\$118.80	\$34,870	\$149.94
\$120,000	\$78,000	\$123.24	\$50,400	\$129.62	\$38,040	\$163.58
\$130,000	\$84,500	\$133.50	\$54,600	\$140.42	\$41,210	\$177.20

Coverage	Coverage	Ages 70-74	Coverage	Ages 75-79	Coverage	Ages 80+
\$140,000	\$91,000	\$143.78	\$58,800	\$151.22	\$44,380	\$190.82
\$150,000	\$97,500	\$154.10	\$63,000	\$162.04	\$47,550	\$204.48
\$160,000	\$104,000	\$164.32	\$67,200	\$172.84	\$50,720	\$218.10
\$170,000	\$110,500	\$174.60	\$71,400	\$183.64	\$53,890	\$231.72
\$180,000	\$117,000	\$184.86	\$75,600	\$194.44	\$57,060	\$245.36
\$190,000	\$123,500	\$195.12	\$79,800	\$205.26	\$60,230	\$259.00
\$200,000	\$130,000	\$205.40	\$84,000	\$216.06	\$63,400	\$272.62
\$210,000	\$136,500	\$215.68	\$88,200	\$226.86	\$66,570	\$286.26
\$220,000	\$143,000	\$225.94	\$92,400	\$237.66	\$69,740	\$299.88
\$230,000	\$149,500	\$236.20	\$96,600	\$248.46	\$72,910	\$313.50
\$240,000	\$156,000	\$246.48	\$100,800	\$259.26	\$76,080	\$327.14
\$250,000	\$162,500	\$256.76	\$105,000	\$270.06	\$79,250	\$340.78
\$260,000	\$169,000	\$267.16	\$109,200	\$280.86	\$82,420	\$354.40
\$270,000	\$175,500	\$277.30	\$113,400	\$291.66	\$85,590	\$368.04
\$280,000	\$182,000	\$287.56	\$117,600	\$302.48	\$88,760	\$381.68
\$290,000	\$188,500	\$297.82	\$121,800	\$313.28	\$91,930	\$395.30
\$300,000	\$195,000	\$308.10	\$126,000	\$324.08	\$95,100	\$408.92
\$310,000	\$201,500	\$318.36	\$130,200	\$334.88	\$98,270	\$422.56
\$320,000	\$208,000	\$328.64	\$134,400	\$345.68	\$101,440	\$436.20
\$330,000	\$214,500	\$338.90	\$138,600	\$356.48	\$104,610	\$449.82
\$340,000	\$221,000	\$349.18	\$142,800	\$367.28	\$107,780	\$463.46
\$350,000	\$227,500	\$359.46	\$147,000	\$378.08	\$110,950	\$477.10
\$360,000	\$234,000	\$369.72	\$151,200	\$388.90	\$114,120	\$490.72
\$370,000	\$240,500	\$380.00	\$155,400	\$399.70	\$117,290	\$504.36
\$380,000	\$247,000	\$390.26	\$159,600	\$410.50	\$120,460	\$517.98
\$390,000	\$253,500	\$400.54	\$163,800	\$421.30	\$123,630	\$531.60
\$400,000	\$260,000	\$410.80	\$168,000	\$432.10	\$126,800	\$545.24
\$410,000	\$266,500	\$421.08	\$172,200	\$442.90	\$129,970	\$558.88
\$420,000	\$273,000	\$431.34	\$176,400	\$453.70	\$133,140	\$572.50
\$430,000	\$279,500	\$441.60	\$180,600	\$464.50	\$136,310	\$586.12
\$440,000	\$286,000	\$451.88	\$184,800	\$475.30	\$139,480	\$599.76
\$450,000	\$292,500	\$462.16	\$189,000	\$486.10	\$142,650	\$613.40
\$460,000	\$299,000	\$472.42	\$193,200	\$496.90	\$145,820	\$627.02
\$470,000	\$305,500	\$482.70	\$197,400	\$507.70	\$148,990	\$640.66
\$480,000	\$312,000	\$492.96	\$201,600	\$518.52	\$152,160	\$654.30
\$490,000	\$318,500	\$503.22	\$205,800	\$529.32	\$155,330	\$667.92
\$500,000	\$325,000	\$513.50	\$210,000	\$540.12	\$158,500	\$681.56

DEPENDENT LIFE CHILD MONTHLY PREMIUMS

Monthly premium for Dependent Life Child coverage is \$1.24, regardless of the number of children covered.

LONG TERM CARE MONTHLY PREMIUMS*

OPTION 1 (DISABILITY)

2008 LONG TERM CARE RATES*							
OPTION 1 (Disability)							
Return of Contribution Excluded				Return of Contribution Included**			
AGE	Per \$10	AGE	Per \$10	AGE	Per \$10	AGE	Per \$10
20	0.20	60	6.64	20	0.22	60	7.20
21	0.24	61	7.18	21	0.24	61	7.72
22	0.26	62	7.76	22	0.26	62	8.28
23	0.28	63	8.38	23	0.28	63	8.90
24	0.30	64	9.08	24	0.32	64	9.56
25	0.34	65	9.84	25	0.36	65	10.26
26	0.38	66	10.66	26	0.40	66	11.16
27	0.40	67	11.54	27	0.42	67	12.16
28	0.44	68	12.52	28	0.46	68	13.28
29	0.48	69	13.56	29	0.52	69	14.48
30	0.54	70	14.72	30	0.56	70	15.84
31	0.58	71	15.98	31	0.62	71	17.34
32	0.62	72	17.32	32	0.68	72	19.00
33	0.70	73	18.80	33	0.74	73	20.82
34	0.76	74	20.38	34	0.82	74	22.88
35	0.82	75	22.16	35	0.90	75	25.14
36	0.90	76	24.08	36	0.98	76	27.68
37	0.98	77	26.12	37	1.08	77	30.46
38	1.08	78	28.30	38	1.18	78	33.50
39	1.18	79	30.44	39	1.30	79	36.60
40	1.30	80	32.52	40	1.42	80	39.76
41	1.40	81	34.44	41	1.56	81	42.84
42	1.54	82	36.14	42	1.72	82	45.82
43	1.68	83	37.60	43	1.88	83	48.60
44	1.84	84	38.92	44	2.06	84	51.30
45	2.00	85	40.12	45	2.24	85	53.92
46	2.18	86	41.20	46	2.44	86	56.46
47	2.36	87	42.18	47	2.64	87	58.92
48	2.56	88	43.02	48	2.88	88	61.32
49	2.78	89	43.84	49	3.10	89	63.80
50	3.02	90+	44.66	50	3.36	90+	66.46
51	3.24			51	3.66		
52	3.52			52	3.94		
53	3.82			53	4.26		
54	4.14			54	4.62		
55	4.48			55	4.98		
56	4.84			56	5.38		
57	5.26			57	5.80		
58	5.68			58	6.24		
59	6.14			59	6.70		

* Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.

** For more information on Return of Contribution, see page 142 of your Insurance Benefits Guide.

LONG TERM CARE MONTHLY PREMIUMS*

OPTION 2 (SERVICE REIMBURSEMENT)**

2008 LONG TERM CARE RATES*							
OPTION 2 (Service Reimbursement)**							
Return of Contribution Excluded				Return of Contribution Included***			
AGE	Per \$10	AGE	Per \$10	AGE	Per \$10	AGE	Per \$10
20	0.28	60	5.02	20	0.28	60	5.14
21	0.28	61	5.52	21	0.30	61	5.66
22	0.30	62	6.06	22	0.32	62	6.22
23	0.34	63	6.70	23	0.34	63	6.86
24	0.36	64	7.40	24	0.36	64	7.54
25	0.38	65	8.06	25	0.38	65	8.22
26	0.40	66	8.90	26	0.42	66	9.10
27	0.44	67	9.90	27	0.46	67	10.16
28	0.48	68	10.70	28	0.50	68	11.00
29	0.54	69	11.60	29	0.56	69	11.96
30	0.58	70	12.62	30	0.58	70	13.04
31	0.62	71	13.76	31	0.64	71	14.28
32	0.68	72	15.04	32	0.70	72	15.68
33	0.72	73	16.44	33	0.74	73	17.26
34	0.78	74	18.02	34	0.80	74	19.06
35	0.84	75	19.78	35	0.88	75	21.08
36	0.90	76	21.74	36	0.92	76	23.38
37	0.98	77	23.94	37	1.00	77	26.04
38	1.04	78	26.34	38	1.06	78	29.00
39	1.10	79	28.92	39	1.14	79	32.26
40	1.18	80	31.48	40	1.20	80	35.62
41	1.24	81	33.80	41	1.28	81	38.80
42	1.32	82	36.02	42	1.36	82	42.00
43	1.40	83	38.44	43	1.46	83	45.60
44	1.48	84	40.60	44	1.54	84	49.14
45	1.58	85	42.46	45	1.66	85	52.48
46	1.68	86	44.54	46	1.74	86	56.34
47	1.78	87	46.30	47	1.84	87	60.02
48	1.90	88	47.74	48	1.98	88	63.56
49	2.04	89	48.94	49	2.12	89	66.96
50	2.16	90+	49.70	50	2.26	90+	69.80
51	2.32			51	2.40		
52	2.46			52	2.58		
53	2.70			53	2.80		
54	2.94			54	3.04		
55	3.20			55	3.30		
56	3.48			56	3.62		
57	3.82			57	3.94		
58	4.16			58	4.32		
59	4.58			59	4.72		

*Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.

**Includes 50 percent home health care benefit payout.

***For more information on Return of Contribution, see page 142 of the Insurance Benefits Guide.

LONG TERM CARE MONTHLY PREMIUMS*

OPTION 3 (SERVICE REIMBURSEMENT)**

2008 LONG TERM CARE RATES*							
OPTION 3 (Service Reimbursement)**							
Return of Contribution Excluded				Return of Contribution Included***			
AGE	Per \$10	AGE	Per \$10	AGE	Per \$10	AGE	Per \$10
20	0.42	60	6.90	20	0.42	60	7.06
21	0.44	61	7.56	21	0.44	61	7.76
22	0.46	62	8.32	22	0.46	62	8.48
23	0.48	63	9.18	23	0.50	63	9.34
24	0.52	64	10.14	24	0.52	64	10.30
25	0.56	65	11.00	25	0.58	65	11.18
26	0.60	66	12.14	26	0.62	66	12.36
27	0.66	67	13.48	27	0.68	67	13.76
28	0.72	68	14.58	28	0.72	68	14.90
29	0.78	69	15.78	29	0.80	69	16.20
30	0.84	70	17.14	30	0.86	70	17.62
31	0.90	71	18.66	31	0.92	71	19.26
32	0.98	72	20.34	32	1.00	72	21.08
33	1.06	73	22.20	33	1.10	73	23.16
34	1.14	74	24.30	34	1.18	74	25.50
35	1.24	75	26.56	35	1.28	75	28.14
36	1.32	76	29.18	36	1.36	76	31.18
37	1.40	77	32.06	37	1.44	77	34.62
38	1.48	78	35.20	38	1.54	78	38.48
39	1.60	79	38.56	39	1.66	79	42.70
40	1.70	80	41.88	40	1.76	80	47.04
41	1.82	81	44.92	41	1.88	81	51.18
42	1.92	82	47.84	42	1.98	82	55.34
43	2.04	83	50.94	43	2.10	83	59.98
44	2.14	84	53.70	44	2.22	84	64.42
45	2.28	85	55.90	45	2.34	85	68.50
46	2.40	86	58.56	46	2.48	86	73.40
47	2.54	87	60.78	47	2.62	87	78.10
48	2.70	88	62.62	48	2.80	88	82.62
49	2.90	89	64.22	49	2.98	89	87.00
50	3.08	90+	65.14	50	3.18	90+	90.64
51	3.26			51	3.38		
52	3.48			52	3.60		
53	3.80			53	3.92		
54	4.10			54	4.24		
55	4.46			55	4.62		
56	4.86			56	5.02		
57	5.30			57	5.46		
58	5.78			58	5.94		
59	6.32			59	6.48		

* Includes an approximate one percent administrative fee for enrollees whose premiums are payroll- or pension-deducted.

** Includes 100 percent home health care benefit payout.

*** For more information on Return of Contribution, see page 142 of your Insurance Benefits Guide.

2008 MONTHLY INSURANCE RATES FOR PART-TIME TEACHERS

HEALTH

Category I. 15-19 Hours						
Coverage Level	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	MUSC Options	Employer
Employee only	\$139.74	\$223.92	\$260.06	\$266.76	\$325.28	\$130.46
Employee/spouse	\$329.92	\$494.86	\$637.86	\$648.30	\$766.04	\$257.36
Employee/children	\$204.86	\$327.04	\$466.72	\$473.24	\$530.34	\$184.58
Full family	\$409.84	\$595.86	\$867.76	\$878.62	\$945.94	\$301.28

Category II. 20-24 Hours						
Coverage Level	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	MUSC Options	Employer
Employee only	\$ 95.38	\$179.56	\$215.70	\$222.40	\$280.92	\$174.80
Employee/spouse	\$242.42	\$407.36	\$550.36	\$560.80	\$678.54	\$344.86
Employee/children	\$142.10	\$264.28	\$403.96	\$410.48	\$467.58	\$247.32
Full family	\$307.40	\$493.42	\$765.32	\$776.18	\$843.50	\$403.72

Category III. 25-29 Hours						
Coverage Level	Savings	Standard	BlueChoice HealthPlan	CIGNA HMO	MUSC Options	Employer
Employee only	\$ 53.64	\$137.82	\$173.96	\$180.66	\$239.18	\$216.56
Employee/spouse	\$160.06	\$325.00	\$468.00	\$478.44	\$596.18	\$427.20
Employee/children	\$ 83.04	\$205.22	\$344.90	\$351.42	\$408.52	\$306.40
Full family	\$211.00	\$397.02	\$668.92	\$679.78	\$747.10	\$500.12

DENTAL

Coverage Level	Category I. 15-19 Hours			Category II. 20-24 Hours			Category III. 25-29 Hours		
	Employee	Employer	Dental Plus	Employee	Employer	Dental Plus	Employee	Employer	Dental Plus
Employee only	\$ 5.86	\$5.85	\$20.60	\$ 3.86	\$7.85	\$20.60	\$ 2.00	\$9.71	\$20.60
Employee/spouse	\$13.50	\$5.85	\$39.00	\$ 11.50	\$7.85	\$39.00	\$ 9.64	\$9.71	\$39.00
Employee/children	\$19.58	\$5.85	\$42.56	\$17.58	\$7.85	\$42.56	\$15.72	\$9.71	\$42.56
Full family	\$27.20	\$5.85	\$60.96	\$25.20	\$7.85	\$60.96	\$23.34	\$9.71	\$60.96

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AETNA

Long Term Care

Long Term Care, RT 32
151 Farmington Avenue
Hartford, CT 06156

Hotline: 800-537-8521

Fax: 860-952-2024

www.aetna.com/group/southcarolina

APS HEALTHCARE INC.

SHP Mental Health and Substance Abuse

Claims, State of SC

P.O. Box 1307

Rockville, MD 20849

Customer Service: 800-221-8699

Tobacco Treatment: 866-784-8454

Fax: 888-897-8931

www.apshealthcare.com

(password=statesc)

BLUECROSS BLUESHIELD OF SOUTH CAROLINA

SHP Standard Plan, Savings Plan, Medicare Supplemental Plan

P.O. Box 100605

Columbia, SC 29260-0605

Customer Service Center:

800-868-2520

803-736-1576

Fax: 803-699-7675

Medi-Call

BlueCross BlueShield of SC

AF 330

I-20 Alpine Road

Columbia, SC 29219

800-925-9724

803-699-3337

Fax: 803-264-0183

BlueCard

800-810-BLUE (2583)

State Dental Plan, Dental Plus

BlueCross BlueShield of SC

P.O. Box 100300

Columbia, SC 29202-3300

Customer Service: 888-214-6230

Fax: 803-264-7739

www.southcarolinablues.com

BLUECHOICE HEALTHPLAN OF SC

P.O. Box 6170

AX-435

Columbia, SC 29260-6170

Member Services:

800-868-2528

803-786-8476

www.bluechoicesc.com

CIGNA HEALTHCARE HMO

P.O. Box 5200

Scranton, PA 18505-5200

Member Services: 800-244-6224

www.cigna.com

EMPLOYEE INSURANCE PROGRAM

Street Address:

1201 Main Street, Suite 300

Columbia, SC 29201

Mailing Address:

P.O. Box 11661

Columbia, SC 29211-1661

Customer Service:

803-734-0678 (Greater Columbia area)

888-260-9430 (toll-free outside Columbia area)

Retiree Billing: 803-734-1696

Fax: 803-737-0825

www.eip.sc.gov

FRINGE BENEFITS MANAGEMENT COMPANY

MoneyPlu\$

P.O. Box 1878

Tallahassee, FL 32302-1878

3101 Sessions Road

Tallahassee, FL 32303

Customer Service: 800-342-8017

Automated Information: 800-865-FBMC (3262)

Claims Fax: 888-800-5217

Other Fax: 850-425-6220

www.fbmc-benefits.com

(Continued on inside back cover)

Contact Information (Continued from front cover)

THE HARTFORD

Basic Life, Optional Life, Dependent Life

P.O. Box 2999

Hartford, CT 06104-2999

Evidence of Insurability: 800-331-7234

Death Claims: 888-563-1124

Retiree Enrollment /Claims: 888-803-7346, ext. 3648

Conversion: 877-320-0484

MUSC OPTIONS

P.O. Box 6170

AX-435

Columbia, SC 29260-6170

Member Services: 800-821-3023

www.bluechoicesc.com

MEDCO PRESCRIPTION DRUG PROGRAM

SHP, MUSC Options

Claims-Medco Prescriptions

P.O. Box 2277

Lee's Summit, MO 64063-2277

Customer Service: 800-711-3450

www.medco.com

MEDICARE

800-633-4227

877-486-2048 (TTY)

www.medicare.gov

SOUTH CAROLINA RETIREMENT SYSTEMS

P.O. Box 11960

Columbia, SC 29211-1960

Customer Service:

803-737-6800

800-868-9002 (toll-free in SC only)

www.retirement.sc.gov

SOCIAL SECURITY ADMINISTRATION

800-772-1213

800-325-0778 (TTY)

www.ssa.gov

www.socialsecurity.gov

THE STANDARD INSURANCE COMPANY

**Basic Long Term Disability,
Supplemental Long Term Disability**

P.O. Box 2800

Portland, OR 97208

General Information and Claims: 800-628-9696

Fax: 800-437-0961

Medical Evidence: 800-843-7979

www.standard.com

MY HEALTHCARE CONTACTS

Doctors: _____

Dentists: _____

Pharmacies: _____

Hospitals: _____

Other: _____

South Carolina Budget and Control Board

Employee Insurance Program

P.O. Box 11661

Columbia, SC 29211

803-734-0678 (Greater Columbia area)

888-260-9430 (toll-free outside Columbia area)

Web: www.eip.sc.gov

E-mail: cs@eip.sc.gov

